Barriers, challenges and facilitators of implementing the UNICEF UK Baby Friendly Initiative (BFI) in a maternity organisation: a qualitative study of the experiences of maternity staff.

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Abstract

Title: Barriers, challenges and facilitators to successfully implementing the UNICEF UK Baby Friendly Initiative (BFI) in a maternity organisation: a qualitative study of the experiences of maternity staff.

Background: Breastfeeding is widely recognised for its health benefits for both infants and mothers, however it faces significant socio-cultural barriers, particularly in industrialised societies. Many women encounter barriers and challenges that hinder their ability to effectively breastfeed their infants.

In 1994 UNICEF UK introduced the UK national accreditation programme named The Baby Friendly Initiative (BFI). It has recognition in numerous government policy documents across all four UK nations. This accreditation programme was developed to assist both hospital and community-based services, such as maternity and neonatal units, health visiting services and children's centres with promoting close and loving relationships between parents and their infants and supports infant feeding practices.

With published evidence demonstrating the benefits of breastfeeding and the UK government making it a requirement for all maternity units to be accredited to BFI standards, it highlighted a need for research in a local maternity that had their accreditation status removed by UNICEF UK. That was the stimulus which provided the rationale for this study.

Methods: Maternity and neonatal staff participated in face to face and online semi-structured interviews. A qualitative, case study approach involving reflexive thematic analysis identified barriers, challenges and facilitators to successfully implementing the BFI.

Findings: Four themes were developed from the research findings, these are staff training, staff knowledge, time and responsibility for providing infant feeding support**.** Organisational factors such as lack of staff education, lack of resources and confusion regarding whose role it is to support infant feeding; individual factors such as personal and professional feeding experiences and

socio-political factors such as attitudes of women and relatives and the influence of the UK media all present barriers and facilitators to successful implementation of the BFI within the maternity unit.

Conclusion: There is a strong formula feeding culture in the UK which requires commitment of staff and the community to change. Derogatory terms are still being applied to proponents of breastfeeding which is compounded by the UK media messaging. Successful implementation of the BFI relies on midwifery management support and funding for the process. One of the main strengths of this work is the applicability of the findings and recommendations to NHS trusts who wish to successfully implement or maintain the UNICEF UK BFI within their maternity service. What has been contributed to the field of knowledge is highlighting the requirement for managerial belief, support and funding for the BFI, alongside supporting a BFI lead role within their maternity service who is supported by passionate, proactive and educated staff. Transparency of the accreditation process and job expectations of all staff is essential.

Contents

List Of Figures

List of Tables

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Chapter 1 Introduction

This thesis describes a qualitative study which was completed in a maternity unit which recently had BFI accreditation status removed. The aim of the study was to explore the experiences of maternity staff when working with the Baby Friendly Initiative (BFI) to identify the barriers, challenges and facilitators to the successful implementation within a maternity unit.

A qualitative case study design allowed for semi-structured interviews with a range of maternity staff. Reflexive thematic analysis was applied to the data which identified themes which are presented as the findings. Document analysis of job descriptions was completed. The study concludes with short, medium and long term recommendations and areas for future research.

A rationale for completing the study is provided which is supported by a lack of current UK based literature focussing on this particular topic. Ensuring confidentiality and anonymity, a short description of the maternity care provision that is available at the study site is discussed in order to provide context to the findings and discussion. There has been attention paid to the language used throughout this thesis; the terms mother, woman and breastfeeding will be used as these terms were used by the research participants and are present in literature and professional guidelines that are referenced throughout.

1.1 My motivation for conducting this research

What is important for my readers to know is what led me to become the researcher for this PhD study; how did I get to this point and why the subject of the UNICEF UK Baby Friendly Initiative (BFI). There are various sources that state a researcher must understand their own motivations for completing research (Alvesson and Skoldberg 2018) and in order to identify these motivations, deep reflection and soul searching was required (Holmes 2020, Goundar 2025). This was a process that I discovered took time, with a requirement to fully face my personal motivations. On occasions it was a challenge to determine where personal and professional boundaries lay. To best describe my position as a researcher I must start at the beginning of my midwifery career.

At the time of writing this thesis I have been a qualified, registered midwife for 19 years. I graduated from a university on the west coast of Scotland in 2006, having completed clinical placements and the midwifery degree within a trust that was accredited to UNICEF UK BFI standards (UNICEF UK 1995).

Following qualification, I began my first post as a midwife in the north of England. This NHS trust was not BFI accredited, therefore what I heard and witnessed from my colleagues regarding infant feeding, was different to my own experience and how I provided care. There was an 'infant feeding' lead midwife employed at this trust who worked hard to impart her knowledge however it was not until the trust began the UNICEF UK accreditation process that staff education, training and regular practical skills reviews were mandated. This BFI training was regularly met with eye rolls and staff suggesting that attending such sessions was just a waste of their time, on reflection I see that there was a general air of disinterest in the BFI standards and support for those who wished to breastfeed. In 2010 and prior to the trust mandating staff training, I completed an MSc in Health Professional Studies whilst working full time, one requirement of the MSc was to complete a literature review, without completing research and data collection. The topic I choose and title I formed was 'Why do first time mothers choose to breastfeed'. The findings from this review and from feedback I had gained from my postnatal care experience was that many first-time mothers chose to breastfeed due to feeling pressurised into doing so, there was an emphasis on 'Breast is Best', however the practical support was lacking within maternity services and I witnessed firsthand many mothers struggling. Throughout the following years from 2010 the trust successfully gained BFI accreditation (UNICEF UK 2017). In 2014 it was then my time to become a first-time mother and experience care from the other side.

Following what could be described as a very high-risk birth, my daughter arrived one evening. Preterm, by definition, at 36 weeks and two days, she was required to have regular blood glucose monitoring for 12 hours post birth, with subsequent regular feeds for a further 24 hours. I was a midwife, I had education and knowledge, but I had never been a mother before and this 'small' matter did not appear to be recognised amongst my colleagues. Following a

night of successful breastfeeding, my baby's blood glucose level the following morning could not be determined, it was low and within minutes she was taken to the neonatal unit for urgent treatment. My birth complications meant I was unable to get out of bed for at least another 12 hours. The neonatal unit staff informed me that due to ongoing treatment, my daughter could not return to me for me to provide her with a breastfeed and it was suggested that 'she just have formula for now'. Faced with no other options, when I agreed, I was congratulated as being 'a sensible mum'. There was no discussion of hand expressing to ensure an effective milk supply, but I guess and presume that my colleagues thought that as a midwife I knew about this and if I had wanted to do this then I would. But I was a new tired mother, in pain and unable to physically care for my baby, where was my support. Some 36 hours later I was informed that I could attend the neonatal unit to breastfeed my daughter, she was under strict orders that of course she was unaware of, that she must complete this feed successfully or she 'was not allowed' to return with me to the postnatal ward. It was my time to congratulate, she was deemed to have fed effectively and I was allowed to have my baby back. Our breastfeeding journey continued for six months when Elsie made the decision to stop, that six months did not continue without problems. The main problem however was the lack of support. Was there a lack of support for me as it was assumed I knew what to do due to my professional knowledge or was it a lack of knowledge on the maternity care providers part.

Between 2014-2017 there was a noticeable impact of BFI accreditation and staff attitudes, there were two very supportive and effective BFI lead midwives in post, who had clear managerial support. I was employed at this trust for 11 years, 10 of these as a band six midwife, before relocating to the south coast of England to the study site in 2017.

When my employment commenced at the study site, part of my induction to the trust was to attend mandatory training, one session of which included an infant feeding update which lasted for approximately 1 hour, at the time I did not know who the staff member was delivering this update, there was no clear introduction. This was the only BFI education I received at the trust, therefore it

quickly became clear that there was no meaningful current staff BFI education and training programme, which could raise the question that maternity staff may not necessarily be working in line with BFI standards. Due to my prior experience of training at, and working within a UNICEF UK BFI accredited NHS trust, the gaps in training and knowledge for maternity staff within the study site were clear to me and I could not help but form my own ideas of what was lacking regarding infant feeding support knowledge for staff and clinical care for families.

Ten months after my employment began, I saw an advert for a clinical PhD studentship, which was supported jointly by the study site and a local university. There was a call to explore the experiences of maternity staff when working with the BFI in clinical practice. The aim was to explore the barriers and facilitators to successful implementation. Completing an MSc had been a stepping stone for me as I had dreamed of one day completing a PhD, and here was a topic that I clearly had an interest and passion for. As I have mentioned above, I had ideas of where knowledge was lacking, this study could be the tangible proof. As a practising midwife, I wanted to understand what maternity staff thought about the BFI, what value they placed on it and whether they knew why it is recommended for maternity units to implement. I wanted to investigate if maternity staff knew the BFI standards and if so, how well, how confident did they feel providing BFI support to women and babies, what training had they received and by whom and if this was felt to be appropriate for their needs. The expectation of this research from the trust was to identify what those factors are, regarding the BFI, that are difficult for staff to implement within their clinical practice. The PhD study commenced in September 2018.

At the commencement of the study, I was a band six midwife that had recently been successful at interview for the post of postnatal ward lead midwife, answerable to a band seven postnatal lead. My responsibilities were to adopt a helicopter view of the postnatal ward and to ensure safe and fair allocation of families to each staff member and ensure the smooth running of the ward, ensuring that all clinical tasks and medical reviews were completed as required. At this point in my career I had been qualified for 12 years, and this was the

second NHS trust I had worked at since gaining my midwifery degree, however I was still becoming familiar with the hospital policies and processes and getting to know my colleagues. I am friendly and approachable and although I had not formed any strong alliances, I felt a level of respect from my colleagues and my midwifery career experience was welcomed.

Three years later in 2021 whilst the PhD data collection was in progress, I became the BFI lead midwife at a band seven level. On reflection it was at this point that I noticed my positionality as a researcher shift.

1.2 Study aim and objectives

This section outlines the aim and objectives of this research. The rationale stems from the known benefits of breastfeeding coupled with the maternity unit's loss of BFI accreditation status.

With published evidence demonstrating the benefits of breastfeeding for the health of women and babies (Victora et al. 2016; Fallon et al. 2019) and the UK government making it a requirement for all maternity units to be accredited to BFI standards (NHS England 2019), it highlighted a need for research in a local maternity that had their accreditation status removed by UNICEF UK. That was the stimulus which provided the rationale for this study. There is a dearth of literature focussing on the barriers and facilitators of the BFI at local and country levels in the UK (Semenic et al. 2012). This aided the formation of the study aim and objectives. The study addresses a gap in UK based research on the barriers and facilitators to successful BFI implementation within a maternity unit.

1.2.1 Study aim

The aim of this PhD study was to understand the barriers, challenges and facilitators to the successful implementation of the BFI standards within a UK based maternity unit.

1.2.2 Study objectives

The study objectives to meet the aim were to explore the views and experiences of maternity staff when working with the BFI standards in clinical practice and to explore the views of infant feeding lead staff members and

midwifery managers regarding the implementation of BFI standards within their maternity organisation.

The overall aim was to explore and understand the barriers, challenges and facilitators to effective BFI implementation within the study site. Two objectives to meet this aim were 1) to explore maternity staff views and experiences when working with BFI standards in clinical practice and 2) to investigate the perspectives of infant feeding leads and midwifery managers regarding BFI implementation within the organisation.

This study aimed to highlight the realities of staff when embedding BFI guidance into routine maternity care. Findings could highlight areas for improvement and provide evidence which could support optimal implementation processes. With national requirements for BFI accreditation, this research has the potential for wider impact and transferability across UK maternity services. The actual contributions to knowledge are outlined in Chapter 10.

1.3 Organisation of the thesis

The chapters and sub-headings are numbered by section, to assist with cross referencing, section numbers will be present in brackets after the text to which it relates, for example (1.2).

Chapter one has introduced this PhD study including my motivation for completing it (1.1 My motivation for conducting this research, the chapter incorporates the aims (1.2.1) and objectives of the study (1.2.2 Study objectives. Chapter two discusses my positionality (2.1) and reflexivity (2.2) as an insider researcher.

Chapter three provides background and context to this study. Socio-cultural barriers to breastfeeding (3.1),the global context of breastfeeding (3.2) and the BFI is introduced, followed by a discussion of BFI inception and the breastfeeding health benefits for women and babies. In the UK the initiative is referred to as BFI, globally it is termed the Baby Friendly Hospital Initiative (BFHI), both of these terms, BFI and BFHI are present within the appraisal of literature. This is due to the lack of UK based literature and research literature from other countries being included due to their relevance for the study. The

national context of the BFI (3.3) highlights the framework of the BFI and the stages that maternity services follow to gain UNICEF UK BFI accreditation, following this section, the local context of the BFI will be discussed (3.4) with particular attention paid to ensuring anonymity for the study site. Section 3.5 will discuss the context of the UNICEF UK BFI for university settings with section 3.6 providing the rationale for undertaking this study and highlights gaps in research.

Within Chapter 4 there is an appraisal of the qualitative literature which focusses on the BFI/BFHI and barriers to implementation published between 2008-2018. The literature search strategy is discussed (4.1), followed by the review of the studies (4.2) and finally the literature review findings (4.3) which have been categorised into three sets of factors: 1) Organisational (4.3.1); 2) Individual (4.3.2) and 3) Socio-political factors (4.3.3).

Chapter 5 provides an outline of the study methodology. Philosophical perspectives of ontology (5.1.1) and epistemology (5.1.2) are discussed prior to the theoretical framework of constructivism (5.2), case study as the study design (5.3) and limitations to case study (5.4).

The methods chapter follows (Chapter 6). I discuss the peer review process of an interview guide developed for the study (6.1), details of participants and recruitment (6.2) are provided including; identifying the sample (6.2.1), participant inclusion and exclusion criteria (6.2.2) and study recruitment process (6.2.3). Ethical considerations are explained (6.3) including ethical approval application processes (6.3.1) and consent, confidentiality and anonymity aspects (6.3.2). Document analysis (6.4) and direct observation (6.5) as methods utilised within the study are discussed. Section 6.6 discusses semi-structured interviews as the main data collection method and how these were completed, this is followed by a discussion of reflexive thematic analysis for data analysis (6.7)

Chapter 7 highlights the findings from the document analysis of the maternity staff job descriptions (7.1). An introduction to the maternity staff job descriptions (7.2) precedes the discussion for each staff banding. These are band two

maternity support workers (7.3), band three senior maternity support workers (7.4) band five midwives (7.5), band six midwives (7.6), band seven midwives (7.7) and band 8 senior staff/midwifery management (7.8).

Chapter 8 presents the findings from the qualitative research methods and semi-structured interviews.

There are four main themes. The first theme discussed is Staff training (8.3). This is split into sub-themes of local university training (8.3.1), training for midwives (8.3.2) and training for maternity support workers (8.3.3). The second theme Staff knowledge (8.4) has five sub-themes. How maternity staff obtain infant feeding knowledge (8.4.1), Differing knowledge amongst a range of maternity staff (8.4.2), BFI training and knowledge (8.4.3), Integrated model of care and impact on knowledge (8.4.4) and Preparation for UNICEF UK re-assessment visit (8.4.5). Time is the third theme presented (8.5). This theme also has five sub-themes; Time for training (8.5.1), Time to care (8.5.2). Time perception in hospital versus time in the community setting (8.5.3), Less staff results in less time (8.5.4) and Band three support workers (8.5.5). The final theme is responsibility for providing infant feeding support (8.6). This is discussed in the sub-themes of; Band two maternity support workers (8.6.2), Why midwives refer to band three maternity support workers (8.6.3), No time (8.6.4), Forgotten knowledge (8.6.5), The experts (8.6.6), Changing expectations of the band three team (8.6.7).

In Chapter nine (Chapter 9), I discuss the organisational barriers and facilitators to the successful implementation of the BFI alongside the published literature which relates to the main themes (9.1). There is discussion of individual factors including personal and professional feeding experiences of maternity staff which may impact on the implementation of the BFI (9.5). Socio-political factors (9.6) of infant feeding and barriers to successful infant feeding support focussing on attitudes of women and relatives (9.6.1) and the influence of the UK media (9.6.2) conclude the chapter.

Chapter 10 (Chapter 10) includes the conclusion and recommendations for practice which are determined as short (10.1.1), medium (10.1.2) and long term

actions (10.1.3). Areas for future research are presented (10.2). Section 10.3 highlights the strengths and limitations of this study.

The reference list and appendices follow chapter 10.

Chapter 2 Positionality and Reflexivity

2.1 Positionality

My positionality did change throughout the study, I feel that my promotion to a senior band altered the view of me from some participants, some of these areas are discussed here. My position as a senior midwife and researcher was multi-dimensional which could have had in impact on the balance of power in the researcher-participant relationship (Dhillon and Thomas 2019). I recognised that I was embedded in the area that I was researching and was aware of my potential to influence the research process and context. As an 'insider' researcher I had been party to critical BFI information (Goundar 2025) and at times there was a need to mitigate for the potential power change by considering how I viewed myself and how others viewed me.

2.2 Reflexivity

Glaser (1978) wrote that:

> "Human beings are not passive receptacles into which data is poured and are not scientific observers who can dismiss scrutiny of values by claiming scientific neutrality and authority".

Whether a participant or researcher, prior experiences will have shaped us in some way and result in assumptions about what is real. Regardless of these assumptions, it is the researcher who has an obligation to be reflexive about what is brought to the research, what is seen and how it is seen (Charmaz 2006).

Charmaz (2006) writes that reflexivity is the process of the researcher to continuously reflect on how their own actions, values and perceptions impact upon the research setting and how these can have an effect on data collection and analysis, however Hughes and McSherry (2025) discussed numerous definitions of reflexivity, with suggestions of it being thought of as more a process than deep reflection. A continuous reflective process has been highlighted as an essential element in the process of data collection, the definition provided by Alvesson and Skoldberg (2018) is one that resonated with me, they state that for a researcher to be truly reflexive, they must understand their motivations for the research thereby ensuring it transcends the

researchers reflections (Alvesson and Skoldberg 2018). The process of reflexivity in research has been long debated, Glaser (2001) wrote that the nature of analysis associated with reflexivity may become destructive to free-thinking and warned that creative processes throughout the research process should not be stifled by the 'introspective drive to justify the outcome' (Glaser 2001). Further thinking by Cutcliffe (2003) suggests that researchers may never truly understand themselves which can impact reflexivity. To be reflexive involves reflecting upon our own views, beliefs and experiences, my views and experiences have been highlighted within my motivation. At best as an insider researcher, I mitigated my own influence on data collection and analysis by bridging the gap between my existing understanding and theoretical sensitivity (Hughes and McSherry 2025).

What individuals bring to a study also has influence over "what we can see" and that qualitative research relies on those who conduct it (Charmaz 2006). Having some experience of working with the BFI assisted with forming the semi structured interview guides. There were areas in which I hoped to gain specific answers, I wanted staff to tell me they had no training and would like some, this would affirm my own beliefs. Other areas I hoped to keep generic and made a conscious effort not to steer my participants answers in any way. What did become apparent was that I could not separate my midwifery experience from my researcher role, I was an insider researcher and that could not be changed. Published literature discusses that to identify oneself as either a researcher or a midwife who is carrying out research is an ethical issue and that by highlighting this role may change colleagues' perceptions (Gillham 2005), it may make participants more cautious. This was the case on occasion, some staff were wary of participating as they felt that the process was a knowledge check. Questions that were asked while giving consent included, 'what if I do not know the right thing to say' and 'are you going to tell on me if I say the wrong thing', I felt that these questions owed to a shift in power balance and my position as the BFI lead midwife at this time. Due to the relationships that I had built up with these staff members, I was able to reassure them of the aim of the study and that it was their voice and experiences that were the focus. They consented to participate and commented afterwards that 'the interviews were not as bad as

expected'. Explaining my role as a midwife researcher did make some participants more helpful. Colleagues and managers both commented on what the BFI role ideally would look like, what was to be expected within the job and the traits that would be beneficial for an effective lead midwife.

There were numerous times throughout the interviews where, when answering a question, my participant would say "you know", in a conversational tone. At times I feel that this inhibited me from exploring their thoughts more as I was aware of what they were discussing and what the meanings were behind their words.

At times, recruitment of participants was very interesting. At the beginning of the recruitment process, I was approached by four participants who were very keen to be included in the study. On reflection, I can now see the reason for this, these participants either had personal experiences which were not necessarily positive for them regarding their own breastfeeding journey, they lacked BFI training and others shared frustrations about other clinical departments within the hospital trust where they had received care. I reflected about this at the time, I was unsure about what, if anything, they wanted from me or was there something they felt I could do for them. Cutcliffe (2003) discusses that emotional transference from participants can influence the research and investigation and at times there was a feeling that the interviews were a mode for them to talk about their negative experiences, like a therapy session. There were times participants became physically upset when talking about their personal infant feeding experiences which made me feel quite helpless as I was conscious about maintaining my professional researcher role. Another interesting point that I was acutely aware of during two of the interviews was the participants swearing. I feel in these situations this demonstrated there was a trusting and mutually understanding relationship between the participants and I, resulting in an emotionally and psychologically safe environment. I presumed that there was a level of comfort for them to use what are deemed as swear words although at the time this made me feel slightly uncomfortable as I was unsure of how I would transcribe these or how they would be published.

Although there will inevitably have been some effects on data collection by highlighting my role as a midwife researcher, these were unavoidable consequences. Not to identify myself as being in a research role whilst acting as a 'normal' member of the team would result in completing covert research. A method of data collection for this case study was to observe maternity staff during shift handover and so it was made known in handover that observation was being completed in order to inform subsequent interview questions. The ethically safest stance is that of being overt about ones' role and purposes as a researcher (Gillham 2005).

Reflexivity as a researcher involved continuously reflecting on my values and perceptions that may have had an impact on the researcher. At the start of the PhD I was an experienced clinical midwife and a BFI lead midwife with many years working with BFI standards. This experience gave insight for the development of the interview questions although I had made prior assumptions regarding a lack of education and training for staff. My position as a colleague encouraged and supported openness from participants however there were some midwives who questioned if BFI knowledge was being assessed rather than exploring their experiences. There were opportunities where deeper exploration could have occurred during the interview process, instead familiarity with the BFI meant that I understood what participants were discussing although they may not have been explicit. I remained overt regarding my role as midwife researcher ensuring that participants were always clear of my role in the process.

Chapter 3 Background and context

This chapter provides an overview of the Baby Friendly Initiative (BFI) in the United Kingdom (UK), including the background and the rationale supporting its introduction. The chapter includes a discussion of socio-cultural barriers to breastfeeding, the global, national and local context of the BFI before providing the rationale for this study.

UNICEF UK is a charitable organisation which benefits from the UK government support therefore situating it in a highly influential position. They are not a statutory or regulatory body however UNICEFs global reputation, evidence-based guidelines and alignment to human and children's rights are respected. UNICEF have developed standards to support close and loving relationships between infants and their parents with evidence based guidance to support infant feeding, the BFI.

The BFI is an evidence-based change management accredited programme which was initially developed in 1994. UNICEF UK developed the programme in response to complex barriers to breastfeeding in the UK which are experienced by women and midwives. Socio-cultural barriers, a lack of education provided to women and postnatal care and support which is lacking, are factors which impact and undermine women's ability to initiate or continue to breastfeed their infants. Hospital practices compound these barriers for women such as readily available and frequent use of formula for supplementation and separation of mother and infant in maternity units where 'rooming in' may not be the norm. Hospital practices and maternity system constraints are barriers for midwives to provide optimal breastfeeding support including lack of time, lack of training amongst staff and inconsistent or absent hospital policies. These factors triggered the development of an evidence-based response, the UNICEF UK BFI (UNICEF 1995). The purpose was to standardise care in the UK, initially through the 'Ten Steps to Successful Breastfeeding (UNICEF UK 2014), to ensure that maternity staff and women received the education and guidance to support a supportive breastfeeding environment. Following a review of ongoing and emerging evidence (Entwhistle 2013), the BFI was updated in

2017 and 2024 with the incorporation of community services, alongside maternity services, to support breastfeeding and supporting close and loving parent-infant relationships (UNICEF 1995, 2017, 2024). The UK government has been a proponent of the BFI standards since their inception and demonstrate support of NHS trusts having accreditation as seen within various policy documents (NHS England 2019, NHS England 2023). By working in partnership with the government and NHS trusts, the aim of the BFI is to support maternity and community services to provide high quality and consistent standards of infant feeding care and support nationwide. The lack of statutory or regulatory capacity of UNICEF UK leads to a variable uptake in the BFI, many NHS have sought accreditation however there are many who do not.

3.1 Socio-cultural barriers to breastfeeding in the UK

Breastfeeding is widely recognised for its health benefits for both infants and mothers however it faces significant socio-cultural barriers, particularly in industrialised societies. While the World Health Organization (WHO) and UNICEF emphasise exclusive breastfeeding for at least the first six months of life up to the age of two years, many women encounter barriers and challenges that hinder their ability to follow this guidance. These barriers include unsupportive workplace policies, misinformation on infant nutrition, stigmatisation of breastfeeding in public and the societal sexualisation of women's bodies and breasts and a lack of community support. This chapter delves into these socio-cultural factors and examines their impact on breastfeeding practices, drawing on empirical studies and theoretical frameworks to highlight the complexities mothers face in navigating breastfeeding within contemporary socio-cultural landscapes.

Feminist movements advocating for women's autonomy and equality have led to increased opportunities in education, careers and social engagement. However, the resulting expectations can sometimes conflict with the demands of breastfeeding as many mothers may feel pressure to return to their pre-baby routines swiftly. Social media often amplifies these expectations by promoting ideals of rapid postpartum recovery and return to work, which can make prolonged breastfeeding appear incompatible with modern lifestyles that does

not fit in with the family life (Brown 2016). Therefore, on the one hand feminist ideals support a woman's right to breastfeed, on the other these ideals may inadvertently reinforce societal expectations that prioritise productivity at work and physical appearance over maternal health. Balancing these competing pressures may be a challenge for many women, illustrating the need for feminist discourse to encompass diverse experiences, including the realities of motherhood and breastfeeding.

Returning to work presents a significant barrier to breastfeeding continuation. Although maternity leave and flexible working policies exist in the UK, they are often insufficient in supporting breastfeeding mothers. Many women reported inadequate facilities for expressing and storing breast milk in the workplace and the absence of private spaces for milk expression and safe storage of expressed human milk compounds the issue, figures from 2019 demonstrates that 47.1% of women globally participated in the labour force and with negative reactions from colleagues discouraging women from breastfeeding, this statistic underscores the importance of supportive workplace policies for breastfeeding mothers. Evidence shows that employer provided support such as designated lactation and expressing rooms and time allowances for milk expression can significantly enhance breastfeeding rates among working mothers. (Vilar-Compte et al. 2021). Without policies which allow time, space and support for breastfeeding, mothers often face the difficult choice of either compromising their commitment to breastfeeding or jeopardising their employment, this intersection of employment and breastfeeding emphasises the need for policy reforms that consider not only maternal health but also family and societal wellbeing (Vilar-Compte et al. 2021).

Breastfeeding and human milk provides irreplaceable immunological, neurological and economic benefits that formula milk cannot fully replicate (McFadden et al. 2016), therefore misinformation and misconceptions about infant nutrition plays a substantial role in undermining breastfeeding efforts and contributes to the declining rates of breastfeeding by instilling doubts amongst women and society regarding the advantages and necessity of breastfeeding (Chong et al. 2022). Although extensive research highlights that human milk is

nutritionally superior to formula, aggressive formula marketing has propagated myths that formula is as beneficial as breast milk and despite international guidelines on marketing practices for breastmilk substitutes, enforcement by the UK government remains weak by allowing formula companies to promote their products as convenient and equally nutritious alternatives. This may influence public perceptions, leading some mothers to believe that formula feeding is comparable to breastfeeding, therefore the need for strengthening regulatory codes, such as The Code (WHO 1990) and public education campaigns that emphasise the unique health benefits of breastfeeding are critical steps toward mitigating this barrier (McFadden et al. 2016).

The public's perception of breastfeeding is deeply intertwined with societal norms surrounding female modesty and body image. Many women face stigmatisation for breastfeeding in public due to the cultural sexualisation of breasts. Objectification theory explains how women internalise societal messages that their bodies are primarily objects for sexual gratification, which can lead to discomfort with breastfeeding in public. Women who internalise self-objectification may experience heightened self-consciousness and apprehension about breastfeeding outside the home, perceiving it as a challenge to societal expectations of modesty (Johnston-Robledo et al. 2007). Studies have shown that people who view breasts predominantly as sexual objects often express discomfort with public breastfeeding, Acker (2009) notes that those uncomfortable with breastfeeding in public tend to lack familiarity with it or harbour sexist views. Public reactions often include embarrassment or disgust at the visibility of bodily fluids during breastfeeding (Brown 2016, Morris et al. 2016). Such attitudes illustrate a dichotomy in societal expectations where women are simultaneously expected to embody chastity and modesty while conforming to unrealistic beauty standards that objectify their bodies (Klepp and Storm-Mathisen 2005, Grant 2016). These conflicting pressures contribute to a pervasive stigma against breastfeeding in public spaces, complicating efforts to normalise this natural and healthy practice.

The role of community support, which includes peer support networks and healthcare resources is crucial to successful breastfeeding. Peer support has

been documented as being integral to breastfeeding initiation and continuation, however in the UK, Grant et al (2017) observed an inconsistent provision of peer support services across the country. This variation stems from localised funding mechanisms which are often misaligned to the actual needs of communities based on birth rates or demand for breastfeeding support (Chepkiuri et al 2020). Despite evidence that breastfeeding peer support can improve breastfeeding outcomes, these programmes are frequently undervalued with funding decisions based on economic constraints rather than health benefits. The closures of children's centres and community-based support groups compound these issues as for many mothers, these centres served as accessible spaces where they receive guidance and validation from experienced peers (Chepkiuri et al 2020). This lack of consistent community support not only limits mothers' access to practical assistance but also deprives them of the encouragement from peers which may be needed to continue breastfeeding through challenging periods.

Other socio-demographic factors, such as education level, age and employment status play a significant role in shaping attitudes toward breastfeeding. Research indicates that mothers with lower educational attainment are more likely to discontinue breastfeeding earlier, a trend likely influenced by limited access to information on breastfeeding benefits and lower social support. Additionally, young mothers and those from lower socioeconomic backgrounds often encounter greater challenges, as they may lack the resources or familial encouragement needed to sustain breastfeeding (Mangrio et al. 2017)

The relationship between socio-demographic characteristics and breastfeeding practices points to broader social inequities that affect maternal and child health outcomes. Addressing these disparities requires targeted interventions that consider the unique needs of vulnerable groups, as well as public health campaigns that make breastfeeding information accessible and culturally relevant to diverse populations.

Breastfeeding presents physical challenges that can discourage mothers, especially when adequate support is lacking. Difficulties with infant attachment, issues with milk production, and common complications like engorgement or

mastitis often lead to breastfeeding cessation. Hospitals and healthcare providers play a critical role in helping mothers address these challenges, yet pressures on healthcare staff can reduce breastfeeding support to a “tick-box exercise,” diminishing the quality of care provided. Investing in healthcare staff training on breastfeeding support, creating robust breastfeeding policies and promoting responsive feeding practices are essential measures to improve breastfeeding outcomes. Hospitals that provide adequate antenatal and postnatal support can significantly enhance a mother’s breastfeeding experience, ultimately contributing to higher breastfeeding rates (Brown 2016).

In examining the socio-cultural barriers to breastfeeding, this section highlights the multifaceted challenges that mothers face in adhering to recommended breastfeeding practices. From community support deficiencies and workplace barriers to misinformation, societal stigma and physical challenges, these issues illustrate the need for a holistic approach to breastfeeding advocacy. Recognising that low breastfeeding rates reflect broader societal dynamics enables policymakers, healthcare providers, and communities to work collectively to foster a supportive environment for breastfeeding. Addressing these socio-cultural barriers will require concerted efforts across multiple sectors to ensure that all mothers have the resources, support and freedom to make the best choices for their infants and themselves.

3.2 Global context of breastfeeding and BFI

The Baby Friendly Hospital Initiative (BFHI) was introduced globally in 1991 by the World Health Organization (WHO) and the United Nations’ International Children’s Emergency Fund (UNICEF) to implement practices that promote, protect and support breastfeeding (UNICEF 2018). It was developed following the 1990 Innocenti Declaration which recognised the right of an infant to nutritious food and set international agendas (UNICEF 2006). This right of an infant was incorporated in the Convention on the Rights of the Child (United Nations 1989)

In 2011, the United Nations identified a need for a global policy to ensure that nutrition was a high priority in order to meet the eight 'goals' as set by their Millenium Developmental Goals (MDG). One of which was to "target extreme poverty and improve nutrition" (2011). In the same year, WHO published a statement supporting their previous global recommendations (2001) that "mothers exclusively breastfeed infants for the child's first six months", thereafter breastfeeding up to the age of two or beyond which should support nutritious complementary foods (World Health Organisation 2011). These recommendations were based on current evidence from a systematic review by Kramer and Kukuma (2009) whose findings demonstrated that exclusively breastfed infants for six months experience less morbidity from gastrointestinal infections and for the woman, prevented pregnancy and aided weight loss. Kramer and Kukuma revised this review in 2011 and although the previous overall conclusions had not changed, new evidence was included from their Promotion of Breastfeeding Intervention Trial (PROBIT) study in 2000. The findings suggested that exclusive breastfeeding for six months demonstrated no long-term impact on growth, obesity, allergic diseases such as eczema and asthma, cognitive ability or behaviour (Kramer and Kakuma 2012). 2013 saw UNICEF request for the "breastfeeding debate to be re-energised" and to incorporate many elements into breastfeeding promotion to ensure success. Each nation became responsible for translating global targets into their own national targets based on their own risk factors, trends and epidemiology.

The 2016 Lancet series, comprising of two systematic reviews, (Victora et al. 2016) was an important contribution to the emerging scientific evidence regarding the importance of breastfeeding. Victora et al. (2016) reported on the outcomes for women and children that were associated with breastfeeding. They found that breastfeeding was associated with a reduction in sudden infant death syndrome (SIDS), a decrease in necrotising enterocolitis (NEC), a reduction in diarrhoea and subsequent morbidity related to hospital admissions, and protection against respiratory infections (Victora et al. 2016). There was consistent evidence that breastfeeding offered major protection against mortality due to infectious diseases, otitis media during the child's first two years and a two-thirds reduction of malocclusions (Victora et al. 2016). There was

limited evidence to support that breastfeeding might offer protection against allergic rhinitis and no evidence of an effect of breastfeeding on weight at six months of age however there is evidence to suggest that breastfeeding offers protection against obesity in childhood, adolescence and adulthood (Victora et al. 2016). This systematic review agreed with findings of Kramer and Kukumas 2012 review where it was found that there was no evidence supporting an association between eczema and breastfeeding, inconclusive evidence for a link between breastfeeding and the risk of asthma and wheezing and no evidence in a reduction of systolic blood pressure in childhood, adolescence and adulthood. Victora et al. (2016) found a consistent effect of an increased intelligence quotient (IQ) of approximately three points. There was restricted evidence as to the protection against type two diabetes although there were only six studies included within this review, the role of breastfeeding on post-partum weight loss could not be ascertained and there was insufficient evidence to support a protective factor of breastfeeding on osteoporosis (Victora et al. 2016), this factor was limited to four studies included within the review.

With supporting evidence, breastfeeding has been promoted as being important for the lifelong health of a child. Improved rates of breastfeeding practices reduces costs for health facilities, families and governments as breastfeeding is known to reduce morbidity. The health benefits of breastfeeding for both mother and child are widely documented. For the child the benefits include an increased IQ, regular school attendance, a potential lower risk of asthma, obesity, type one diabetes (Lampousi et al. 2021), sudden infant death syndrome (SIDS), many infections and they are more likely to achieve a higher income in adult life (Victora et al. 2016). For the woman there are benefits of a reduction in the risk of female cancers such as breast and ovarian cancer (Victora et al. 2016), diabetes in later life and it is suggested that breastfeeding is associated with maternal cardiovascular health benefits (Nguyen et al. 2017). Breastfeeding promotes the formation of close and loving relationships, improving the mental health of both mother and baby and aids the brain development of the infant, yet it requires support, encouragement and guidance (Victora et al. 2016).

3.3 National context of BFI

Although established in 1992, it was a further two years before UNICEF UK introduced the UK national accreditation programme named The Baby Friendly Initiative (BFI). It has recognition in numerous government policy documents across all four UK nations (NHS England 2019, 2023). This accreditation programme was developed to assist both hospital and community-based services, such as maternity and neonatal units, health visiting services and children's centres. The programme assists by enabling these services to better support families with infant feeding by providing a 'road map' to follow which transforms care for babies, mothers and families (UNICEF UK 2017). This roadmap provides a guide on how to apply the evidence-based information to infant feeding support and help parents to build a close and loving relationship with their baby. This initial 1994 programme provided healthcare facilities with guidance which followed the BFHI standards named "the ten steps to successful breastfeeding". The standards aimed to provide guidance for improvements in maternity services which were sustainable, meaning that it was not difficult for hospital and community-based services to maintain the "Ten steps" in the long term. UNICEF UK aimed to provide support and training to maternity services in order for them to successfully implement the BFI standards with continuing auditing and monitoring of their progress (UNICEF 1995). In 2018, UNICEF UK published a guidance document which aimed to provide health care organisations with a clear direction for implementing the BFI standards so that they were effective immediately and were able to be maintained over time (UNICEF UK 2023). For a healthcare service to be considered as achieving sustainability there is a requirement for them to have met the requirements for a full re-assessment which happens two years after gaining initial BFI accreditation. The service must also demonstrate adequate leadership structures (UNICEF UK 2023). Service leaders and managers must support the standards as well as progressing and improving them over time. There must also be an enabling and positive culture within the service which has an awareness of the specific challenges the UK faces regarding infant

feeding. This positive culture must be demonstrated to UNICEF UK during accreditation visits.

In light of emerging scientific evidence, UNICEF UK performed a major review of their 1994 standards. Based on the current, best evidence which supported an increase in breastfeeding prevalence (UNICEF UK 2012), UNICEF UK developed and published a new set of BFI standards in 2012, which were updated in 2017 (UNICEF UK 2017). The basis of the 'ten steps to successful breastfeeding' and another of UNICEF UK's supporting publications titled the 'seven-point plan for sustaining breastfeeding in the community' (UNICEF UK 2013) were incorporated within the updated 2012 accreditation programme. A significant addition being recent evidence promoting the importance of close and loving relationships between parents and babies and how health care professionals can successfully support this relationship building (UNICEF UK 2013).

The National Institute for Health and Care Excellence (NICE) is an independent public body that provides guidance and advice for health professionals to improve health and social care in England. Following rigorous assessment of evidence-based practice, recommendations are developed and published as guidance (NICE 2023). Its maternal and child nutrition policy states that professional bodies should ensure that all health professionals have the relevant skills and knowledge regarding breastfeeding management advice (NICE 2014), specifically that UNICEF UK BFI training should be the minimum standard for all maternity service providers.

BFI training follows a clear framework and assessment criteria (UNICEF UK 2017, 2023). There are administrative steps which are to be completed prior to commencing the three stages to UNICEF UK BFI accreditation. There is a requirement for maternity units to register their intention to work towards Baby Friendly accreditation, this process involves submitting a form to UNICEF UK which then triggers a supportive partnership; an action plan is formulated between the maternity unit and UNICEF UK which is developed solely for that unit. Once an action plan has been completed, a certificate of commitment is applied for which recognises that the maternity unit is committed to the BFI and

has an up to date, evidence based infant feeding policy in place to guide and support staff. The certificate is signed by the head of service demonstrating their commitment, the chief executive of the National Health Service (NHS) hospital and the UNICEF UK BFI programme director. The process of meeting the criteria of the three stages to accreditation then begins.

Stage one is building a firm foundation to support staff working in the maternity service with policies and guidelines, stage two is ensuring the service has an educated workforce and stage three focuses on the experiences of parents who are the service users.

Once each stage is deemed as being complete, the maternity unit applies to be assessed by UNICEF UK, it is dependent on where in the process a maternity unit is, as to what stage is assessed. They are separate stages which can be assessed at different points in time over a set period of years or all three stages can be assessed during one visit by a team of UNICEF UK assessors, over the course of two to three days.

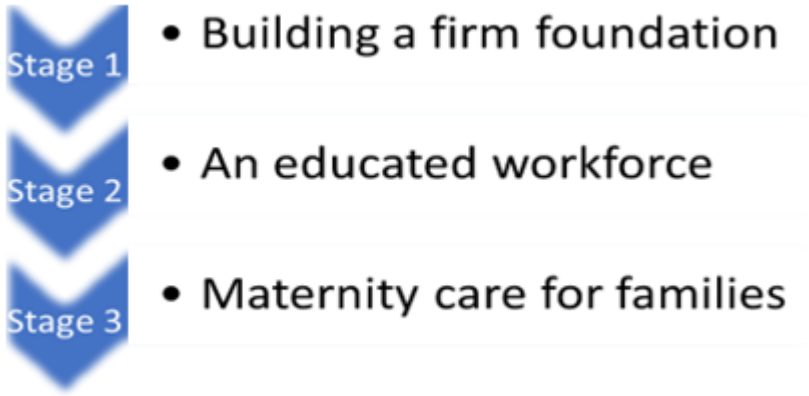

Figure 1 UNICEF UK Standards for health services

Stage one of the accreditation process requires maternity units to have written guidelines which support the BFI standards; to develop a programme of training and education for staff; have processes that support the implementation, evaluating and auditing of the standards and to ensure that staff are adhering to the International Code of Marketing of Breastmilk Substitutes, particularly highlighting that there is to be no promotion of bottle, teats, dummies or breastmilk substitutes (UNICEF UK 2017, 2023; UNICEF UK BFI 2024).

Stage two accreditation is complete when maternity services can demonstrate that staff have been educated as per the training and education programme developed for stage one, this training prepares staff to implement the BFI standards to their job role thereby ensuring that evidence-based care is provided effectively. Internal audits of maternity staff are completed when they have received BFI training, when these audits indicate that staff have the required knowledge and skills, stage two assessment can be completed (UNICEF UK 2017).

Stage three of the process focusses on the experiences of parents. To meet the criteria required for this stage of assessment, maternity units must have supported families with their infant feeding choices. This element incorporates supporting women to recognise the importance of breastfeeding and support them to get breastfeeding off to a good start. Encouraging the development of close and loving relationships between parents and their baby, regardless of feeding method choice is essential. The specific responsibilities for neonatal units completing stage three are to support parents to have close and loving relationships ensuring that they are valued as partners in care for their baby and that all babies are enabled to breastfeed or receive breastmilk.

Once the three stages have been assessed and maternity units are deemed to have met the required criteria, the maternity service is awarded as being BFI accredited. Following this award, a reassessment plan is developed to ensure that the standards are being sustained. Initial BFI accreditation lasts for two years with subsequent re-assessment visits then being completed at regular intervals, typically every three years. The purpose of these re-assessments is to progress through the accreditation process and confirm that the BFI standards are being maintained and to “explore how the maternity service is building upon the work it has already done”. All maternity unit accreditation status is published on UNICEF UKs website (UNICEF UK BFI 2024).

Once initial accreditation has been awarded, the maternity unit continues to gather infant feeding statistics such as breastfeeding initiation, breastfeeding continuation, exclusive breastmilk rates and supplementation rates. These figures are reviewed by the UNICEF UK BFI assessment team who also audit

how effectively the BFI standards are being implemented. The results of these ongoing audits are sent to UNICEF UK on an annual basis to demonstrate that high standards are being maintained, with any required improvements being highlighted and actioned if necessary. The three yearly re-accreditation process involves interviews with women, maternity staff and midwifery managers. The purpose of the interviews are to review the audit results alongside a discussion of how the BFI standards are being sustained within health care services.

In 2016, to support the implementation of the BFI standards and to offer a guide for maternity units, UNICEF UK developed a guidance document titled "Achieving Sustainability standards", the most recent update was January 2023. (UNICEF UK 2023). These standards were developed to be incorporated into the process of achieving and maintaining BFI accreditation regardless of where in the process a maternity unit was or which stage they were aiming to gain accreditation for (one, two or three). Unlike the BFI standards there is no description of how clinical care should be offered, the aim of the guidance is to provide a strong foundation on which care is built by providing a guide for implementing the BFI standards both in the short term and sustainable over time. To be considered by UNICEF UK as a maternity service that is achieving sustainability, they must demonstrate that they have "implemented and maintained the core Baby Friendly standards for at least two years as confirmed by full re-assessment" (UNICEF UK 2023). There must be competent leadership structures in place which support the ongoing maintenance of the BFI standards and who progress and improve those standards in an ongoing way over time. There must also be a protective culture within the maternity service that is positive and enabling for Baby Friendly, making it easier to implement, maintain and monitor. The assessment includes a review of staff culture using a maternity staff survey, audits and interviews with the Baby Friendly guardian, Baby Friendly Lead and supporting team and women using the service. Maternity services who meet the required criteria at this assessment are granted the status of being "re-accredited as Baby Friendly with Sustainability" and receive a gold award. The Baby Friendly award is

prestigious, with services who implement the best practice standards receiving this nationally recognised mark of quality care (UNICEF1995).

UNICEF UK state that they work in collaboration with government policy makers so that legal and institutional frameworks are in place to support children's rights. In 2016 UNICEF UK called on the UK government to take steps which enable mothers to breastfeed for as long as they wish, resulting in the initiative "Call to Action" (UNICEF UK 2016). The 'call' stated that the UK and the devolved governments must acknowledge responsibility and accept the evidence that demonstrates the resounding benefits of breastfeeding and the role it plays in saving lives, improving health and cutting health care costs in countries worldwide rather than blaming women for the poor breastfeeding rates (UNICEF UK 2016). Figure 2 below shows the four key actions that UNICEF UK are asking the government to implement:

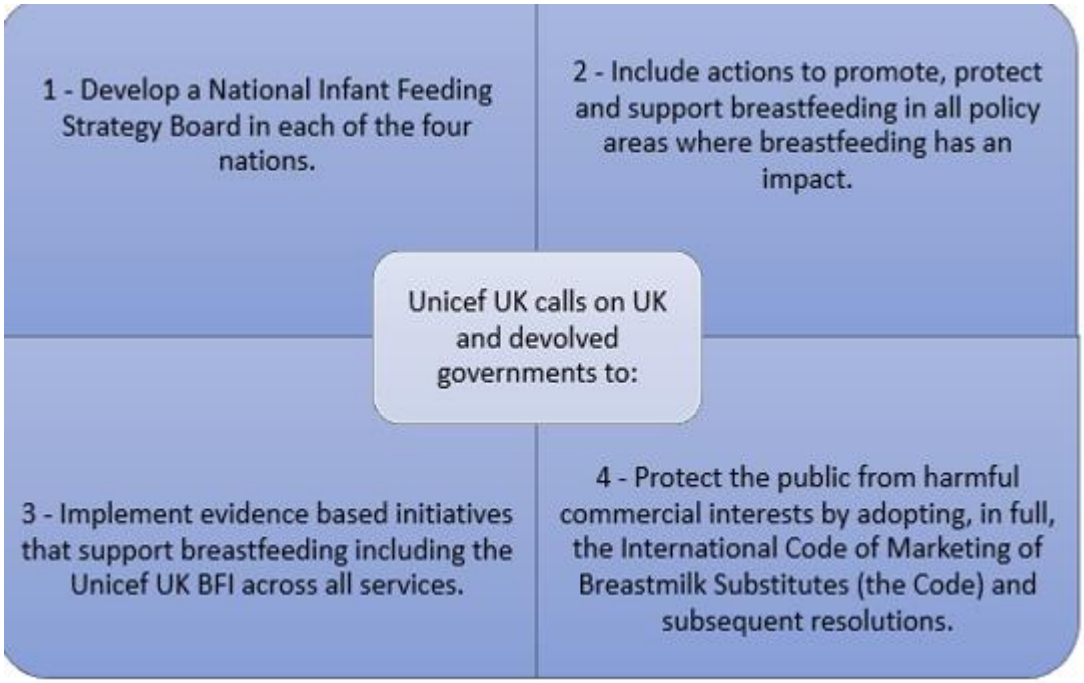

Figure 2 UNICEF UK Call to Action (2016)

The Call to Action (UNICEF UK 2016) covers the four areas as highlighted in figure 2. Target area number one explains to the UK government that each feeding strategy board should be tasked with developing a National Infant Feeding Strategy and Implementation plan, this being initially advised by WHO in 2003. Section two discusses those areas in which breastfeeding has an

impact such as childhood obesity, diabetes prevention in both mother and child and cancer reduction in the mother. Breastfeeding increases emotional attachment, readiness for school, improves maternal and child mental health, wellbeing in the workplace and environmental sustainability (Victora et al. 2016). Implementing the UNICEF UK BFI should occur across all maternity, health visiting, neonatal and children's centres with the promotion of the International Code of marketing of Breastmilk Substitutes (World Health Organization 1981)

The implementation of evidence-based initiatives that are supportive of breastfeeding, including the BFI, is a focus of "Call to Action"; this is also an objective of the NHS Long Term Plan (NHS England 2019). UNICEF UK have identified that the BFI is having a positive impact on breastfeeding initiation and continuation rates in the UK by creating a 'new normal' in health services (UNICEF UK BFI 2014) however even with the development of the BFI and Call to Action, the last national infant feeding survey to be published (McAndrew et al. 2010) documented that only 1% of babies are exclusively breastfed at six months with only 34% of babies receiving any breast milk at the same age (McAndrew et al. 2010).The survey was first completed in 1975 and was carried out every five years until 2010. The purpose was to provide estimated numbers on the incidence, prevalence and duration of breastfeeding for the Health and Social Care information centre who used these figures as information to improve the health and care of the population. In 2015 the survey was discontinued with funding constraints being the reason provided by the government, the onus to collect these breastfeeding statistics was then on local authorities although it was on a voluntary basis. Scotland felt that the survey was beneficial and completed a further survey in 2016, however that was the final one.

Public Health England then began to gather this data and publish breastfeeding rates at six-eight weeks of life, these figures are reliant on being reported by health visitors to their local authority. Current figures for 2021-2022 demonstrate babies who are breastfeeding at six-eight weeks old as 49.2% nationally. The Department of Health and Social care (DHSC) commissioned a

new infant feeding survey for England, the pilot began in late 2023 with the main data collection being completed in 2024. The data to be collected will include questions about how mothers plan to feed their babies, where they access information and advice regarding infant feeding and questions around pregnancy and lifestyle.

There are documented benefits of the BFI (Byrom et al. 2021) and women's experiences and perceptions of infant feeding, so the low rates in the UK must be questioned. It is a complex picture, the UK has a strong bottle-feeding culture (UNICEF UK 2016), with formula being viewed as either nearly as good as or equal to breastmilk. Explanations for such low figures may include breastfeeding being a highly emotive subject with those advocating breastfeeding risking being vilified by the media (9.6.2), the perceptions and views of the public or maternity staff colleagues and inadequate regulation of breast milk substitute advertising and lack of consistent support when breastfeeding (UNICEF UK BFI 2014).

The UK government has published policies and documents which have relevance for this study topic. The NHS Long Term Plan (2019) builds on ideas as set out in the Five Year Forward View (2014), with a view to meet its targets over the five-year span of 2019 to 2024. The Five Year Forward View policy provided a vision for the future of the NHS which was based around new models of care. The document states why it was felt that the NHS needed to change and the government will look at new models of care and how the relationships with patients and communities can be developed, NHS England (NHSE) also document how these changes will be affected. There is a focus on three areas where there are deemed to be widening gaps, they document a funding and efficiency gap, a care and quality gap and a health and wellbeing gap. Regarding health and wellbeing, it is suggested that if the UK nation fails to become serious about ill health prevention, then healthy life expectancy numbers will stall, inequalities will widen, ultimately resulting in a lack of funds available to fund beneficial treatments. The fundamental aim of the Five Year Forward View was to dissolve traditional boundaries of the NHS namely between primary care, community services and hospitals, with services

provided around the patient to improve the health and wellbeing of the population. There are many new care models discussed throughout the document but as the focus of this thesis is maternity care and services, only that area will be discussed here. The plan of the government, as documented in this policy in 2014, was to commission a review of future models for maternity units, this was expected to be completed by 2015 with recommendations on how to develop and sustain maternity units across the NHS (NHS England 2014). NHS England state that the Five Year Forward View sets out a clear direction for the NHS with clinical commissioning groups (CCG's) being funded to have clinical insight and to 'drive' change for their local populations within their local health systems. The level of health care provision depends on a workforce with correct staffing level numbers, skills, values and behaviours to deliver it. Without these factors, any care model, regardless of new or old, will not work. Whilst this policy highlights a necessity of the need to promote health and wellbeing of the population, it does not discuss infant feeding directly.

In 2019 the NHS Long Term Plan was published, also with a five year forward vision until 2024. This government policy document builds on the ideas as set out by the Five Year Forward View and states that the redesign of patient care must be accelerated. Since 2014 the changes as set out in the Five Year Forward View are deemed to be "beginning to bear fruit" (NHS England 2019) and through responses from patient groups, professional bodies and NHS leaders regarding what changes were still needed, funding was secured for the five years from 2019-2024 to implement those changes. Chapter two of the NHS Long Term Plan discusses the action that the NHS will take to strengthen its contribution to prevention and health inequalities and extends the focus from Five Year Forward View to include children's health amongst other priorities. The reason for this particular focus is that England falls behind international comparators in important aspects of child health with young people being increasingly exposed to obesity. The health of children is influenced by many factors, but it is known that a stable and loving family life within a healthy environment increases health and life chances.

There is one sub-section within the NHS Long Term Plan regarding infant feeding, it is worded as:

> "All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019-2020".

In March 2023 NHS England published a maternity and neonatal services delivery plan. The Three-Year Delivery Plan (2023) documents how health care will be personalised and equitable for women, babies and their families, it aims to support change by collating the NHS Long Term Plan (NHS England 2019) and recent maternity services reviews such as the Kirkup report (Kirkup CBE 2022)and the Ockenden report (Ockenden 2022). Kirkup (2022) found that postnatal women were left unsupported with breastfeeding and the Ockenden report (2022) documents that throughout the investigation into maternity services there were concerning negative accounts from women where midwives were described as rude and unprofessional and were too busy to provide infant feeding support. The Three-Year Delivery Plan (2023) states that the voices of service users have been heard via engagement events although it is acknowledged that currently there are low staffing levels throughout the NHS and therefore there is not always time to increase knowledge and learning, alongside a real struggle with time to provide health care to the highest expected standards of those who access and use NHS services. With focus on the BFI, the Three-Year Delivery Plan (2023) states that:

> "It is the responsibility of NHS trusts to achieve the standard of BFI for infant feeding or an equivalent initiative by March 2027".

Achievement of BFI completion will be measured from maternity surveys by the Care Quality Commission (CQC), these surveys will demonstrate the proportion of maternity and neonatal services with accreditation.

Whilst there are now UK government policies and guidance in place supporting UNICEF BFI (NHS England 2019, 2023), the Nursing and Midwifery Council (NMC) have published a professional code and standards since 2002 which highlight the expected standards of practice and behaviour for nurses, midwives and nursing associates. In 2014, NICE stated that collaborative working across

organisations and disciplines is crucial for the BFI standards to be implemented effectively and recommended that BFI training for midwives, neonatal unit staff, support workers, health visitors, dieticians, doctors and pharmacists should become a facet of continuous professional development (NICE 2014) which in turn will lead to improved experiences for mothers and babies (UNICEF UK BFI 2014). The BFI was not a national recommendation until the publication of NICE postnatal care guideline in 2010 (McIntyre and Fraser 2018). The current NMC standards of proficiency were published in 2019 and provide very clear and comprehensive expectations regarding the accountable and autonomous professional's skills and knowledge regarding infant feeding, these expectations are discussed in depth in the discussion section.

The context of the BFI to the local study site will be discussed next.

3.4 Local context of BFI

The local NHS Clinical Commissioning Group (CCG) had detailed strategic principles in its '*Maternity Strategy 2014-2019'* which set out where the priorities were for the development of maternity services and the direction to proceed to meet their objectives. The most relevant priority was that all maternity units within the county were to achieve full accreditation for BFI status with increased breastfeeding rates both at initiation and at six to eight weeks postnatally (CCG 2014), although no end date was set. This local priority was further supported by the UK government in their NHS Long Term Plan (NHS England 2019) and the Three-Year Delivery Plan (NHS England 2023), which both recommend that all maternity services in the UK must deliver the UNICEF BFI programme.

The local integrated care board (ICB), who undertake statutory responsibilities on behalf of the CCG, have published their 'Looking Forward Policy' which leads on from the 2014-2019 strategy and is in response to the NHS Long Term Plan (NHS England 2019). The policy objectives are to be met over the five years spanning 2019-2024, one vision of the policy being that all health care providers within the county are to be accredited to the UNICEF UK BFI by 2023/2024. The CCG in this locality was replaced in 2022 by an integrated care partnership who published their *General Strategy 2022-2023* in conjunction with a *Joint Forward Plan: 2023-2028,* which highlights the expectations of each

organisation included within the care partnership, including local authorities and primary health care services. The *Joint Forward Plan*: *2023-2028* discusses that there is accessible infant feeding information available on a county wide website, that the ICB participates in the local infant feeding network and it states that as a joint partnership board, it has developed initiatives in the local area which create a welcoming environment for breastfeeding parents. The county wide website was accessed as part of analysis for this research where it was discovered that the information is not correct for all maternity units in the locality, it advertises that all midwives and maternity care assistants are educated to provide infant feeding support, which is not the case at the study maternity unit. It appears that the main aim for supporting and advising parents on aspects of breastfeeding is to aid in the prevention and reduction of childhood obesity levels (NHS 2023). The plan also states that the ICB will support organisations to achieve UNICEF UK BFI accreditation. These measurable goals are necessary to receive funding from the NHS Long Term Plan (NHS England 2019).

Local authorities are included within the partnership, with the council having a clear plan for their strategy, it is based on the UK governments policy document '*The best start in life: A vision for the 1001 critical days*' (2021). They document that NHS services can vary and that often families do not receive tailored and individualised care according to their needs. Their aim is to ensure that every baby gets the best start in life by working towards the NHS Long Term Plan (NHS England 2019) commitments, particularly with maternity services. They discuss the use of volunteers to assist with infant feeding and believe that all families should receive a "universal offer", which is for every new family to receive infant feeding advice with specialist breastfeeding support if required.

The Local Maternity and Neonatal System (LMNS) has developed a targeted intervention that is to be completed by the first quarter of 2024/2025. The target to be met is for the implementation of a breastfeeding strategy as well as improving breastfeeding rates. This is to be facilitated by local infant feeding networks who are expected to support an improvement on infant feeding

experiences and outcomes by improving equity of access, efficiency and consistency of care delivery.

The process to gain BFI accreditation had commenced at other local maternity units, however the main research site did not to meet BFI re-assessment criteria to maintain their full accreditation status and were keen to rectify this. Some neighbouring NHS trusts have full BFI accreditation hence the intention to select them to participate in this study to enable either a comparison or contrast to the study site.

3.5 The context of the UNICEF UK BFI for university settings

The UNICEF UK university standards are an extension of the Baby Friendly programme. For the education setting, the accreditation programme is intended for pre-registration midwifery education. The purpose of the university programme is to ensure that midwives are equipped with the basic infant feeding knowledge and skills that they need to incorporate the BFI standards within their clinical practice, from the beginning of their professional career. This will enable them to support infant feeding and relationship building between parents and babies effectively.

Having Baby Friendly accreditation is recognised as a mark of quality in midwifery university programmes with benefits being that it raises the profile of infant feeding and ensures that the evidence has a strong focus and is incorporated within the health care education programmes. The profile of the university itself is raised with NHS trusts and accreditation status can influence potential students who are deciding which university to apply to. The NMC are clear within their 'Standards for Professional practice' (2019) regarding infant feeding and what is required of health care personnel. Where universities implement the Baby Friendly Standards, it will assist with students gaining competency in these infant feeding skills. The Baby Friendly standards are supported by robust evidence which will increase the confidence of students when they are providing feeding support in practice. NHS trusts should recognise the benefit of employing midwives who have had Baby Friendly training at university and clinical experience as a student as they are unlikely to require further infant feeding training other than regular staff updates.

The UNICEF UK BFI accreditation is awarded to individual programmes rather than the university itself, in the university which is linked to the NHS study site, it is awarded to the BSc in Midwifery programme. Universities are provided with a guidance document so that the Baby Friendly learning outcomes which are arranged in five themes can be mapped across the curriculum ensuring that all students are given a strong foundation of evidence-based knowledge to enable them to effectively support mothers with infant feeding and helping parents and families build close and loving relationships with their babies.

Having a BFI lead within the university is beneficial as they will be in a position to oversee the accreditation process and act as the contact point between the university and the UNICEF BFI lead within NHS trusts. The university BFI lead also works with the teaching team to develop, monitor and update the teaching and learning resources, assessments and audits developing an action plan to ensure the BFI standards are both implemented and maintained throughout the curriculum. This action plan should include the timeline for completion of actions and the staff who have responsibility for completing each action and implementing the standards.

3.6 Rationale for the study

Breastfeeding has been evidenced to be important for the lifelong health of a child and reduces costs for health facilities, families and governments, it has a positive effect on a child's development, health and nutrition; for the woman it has both physical and mental health benefits (Fallon et al. 2019). The health benefits for both mother and infant are widely documented, the benefits for the infant include an increased IQ (intelligence quotient), regular school attendance, and a higher income in adult life. For the mother there is a reduced risk of female cancers. Effective breastfeeding requires support, encouragement and guidance (Victora et al. 2016).

Global evidence highlights that there are inequalities in the initiation and continuation rates of breastfeeding which is influenced by the income level of the country (Hernández-Cordero and Pérez-Escamilla 2022). In order to negate these inequalities the Baby Friendly Hospital Initiative (BFHI) was launched. The strategy for the BFHI was to provide a framework that could be applied to

maternity units globally to promote, support and protect breastfeeding (Fallon et al. 2019). In 1994 UNICEF introduced an accreditation programme in the United Kingdom (UK) named the Baby Friendly Initiative (BFI). The difference between the BFHI and BFI is that globally the initiative is embedded within hospitals only, in the UK it supports both hospital and community-based services, such as maternity and neonatal units, health visiting services and children's centres to better support families with infant feeding (UNICEF 1995) some higher education institutions (HEI's) are also accredited. UNICEF have aided with strengthening a focus on nutrition and early childhood development which (UNICEF 2024) will contribute to meeting goals two and three of the United Nations Sustainability Goals (UNSDGs) (United Nations 2022; Walsh et al. 2023).

In 2018, a local maternity unit, which was the study site, had their BFI accreditation status removed by UNICEF UK. Maternity and neonatal unit staff were not equipped with the knowledge to meet the UNICEF UK BFI re-assessment criteria, in a routine visit by UNICEF UK BFI assessors. With evidence demonstrating the benefits of breastfeeding for the health of women and babies (Victora et al. 2016; Fallon et al. 2019) and the UK government making it a requirement for all maternity units to be accredited to BFI standards (NHS England 2019), the outcome of the re-assessment visit highlighted a need for investigation and was the stimulus for this study. This qualitative, case study research explored the views and experiences of UK maternity staff who work within the maternity unit, where BFI standards had previously been implemented but BFI accreditation had subsequently been removed. The aim of the study was to identify the barriers, challenges and facilitators to successfully implementing the BFI standards within the maternity unit. This objective to meet the aim was met by exploring the views and experiences of midwives and maternity support workers when working with the BFI in practice.

The study site provides obstetric led care, a midwife-led birthing service, community midwifery, antenatal and postnatal care, and a home birth service. It also provides level one care within a Special Care baby unit; this means it provides care for healthy full-term babies or stabilising care to prepare preterm

babies for transfer to neonatal facilities that provide advanced care. The birth rate for this unit between the study dates of 2018-2022 have averaged 1,448 births a year (NHS Digital 2023). Most maternity staff work within an integrated care system which means that midwives provide midwifery care through the pregnancy continuum, both in the maternity unit and the community setting; there are a number of midwives who only work night shifts on the maternity unit and there are postnatal ward lead midwives who also only work within the maternity unit. All clinical staff who are employed have responsibility for providing infant feeding support to women and babies, as per their job descriptions. NHS staff all work within a salary scale known as a 'band', at this maternity unit there is a range from band two to eight, with limited staff members employed as a band four support worker. The expectations of staff and job responsibilities as per their band is discussed in chapter seven (Chapter 7).

This research has identified valuable insights into how the BFI could be successfully implemented within a maternity unit, this has been facilitated through the identification of barriers and challenges that must be overcome and the positive facilitators. These findings and recommendations can inform managers, BFI lead staff members and all maternity staff who support women and babies with infant feeding on a daily basis. A systematic review by Fallon et al (2019) found that there was no current data regarding the health outcomes for women and babies in the UK and no clear review of the provision of the BFI. An aim of the BFI is to increase breastfeeding continuation (Fallon et al. 2019) however the current UK rates of total or partial breastfeeding at 6-8 weeks is 52% (www.gov.uk 2024), this rate must be accepted with caution as not all NHS trusts have reported data. For comparison, the study maternity unit has a rate of 56%. The literature search undertaken for this study confirmed that there is no current research of UK based maternity staff experiences when working with the BFI, this dearth of literature highlighted a gap which prompted the need for this qualitative study.

This chapter has demonstrated that the BFI was developed in response to emerging evidence that documents the lifelong health benefits of breastfeeding

for women and babies. The standards provide a framework to support maternity staff, enabling delivery of evidence-based infant feeding support. The requirement for all maternity units in England to achieve accreditation is recommended in UK government policies (NHS England 2019, 2023), however breastfeeding rates remain low which indicates that challenges in providing support are ongoing.

This thesis outlines research that was undertaken to investigate the experiences of maternity staff working with the BFI within a UK maternity unit which lost UNICEF UK accreditation. The aim of the study was to identify barriers, challenges and facilitators to successful implementation of the BFI. The lack of research into the experiences of UK based maternity staff presents the gap in knowledge which this study aims to address. A range of maternity staff were interviewed to explore their views and experiences when working with the BFI, the findings from these provided insight into the barriers to be overcome and facilitators that can be encouraged.

Chapter four presents the literature appraisal.

Chapter 4 Appraisal of literature

Chapter four is the literature review examining barriers and facilitators to implementing the BFI in maternity units. The review synthesises findings from eleven relevant studies published between 2008-2018. The significance of studying factors influencing BFI implementation is noted, given its importance for improving breastfeeding outcomes. An explanation of the literature search strategy is provided which precedes a review of the research studies, tables are provided with overviews of the included studies. The findings from the literature review follow this section and have been organised into organisational, individual and socio-political factors. The majority of the literature which was accessed for the purpose of this study discussed findings within the above three factors, therefore I chose this layout for the synthesis of my data as organisational, individual and socio-political factors became evident throughout data analysis and writing the discussion.

4.1 Literature search strategy

With evidence supporting the BFI and the benefits of breastfeeding for mother and baby, a search of the literature was performed with the aim of identifying the barriers, challenges and facilitators to the successful implementation of the BFI in a maternity organisation. Electronic databases searched were: EBSCO host, CINAHL with full text, Medline, CINAHL plus, Emerald insight, Proquest, Pubmed and Clinicalkey.com via Athens. The search terms used were: Baby Friendly Initiative, BFI, Baby Friendly Hospital Initiative, BFHI AND matern* OR hospital OR unit AND implem* OR barriers. Hand searching of relevant academic journals was performed. To assist with narrowing the search, date range was 2008-2018, articles were limited to those with full text available, in the English language, peer reviewed, evidence-based practice and research articles. Sixteen articles were identified, their reference lists were scanned resulting in a further seven articles.

Following review of the twenty-three research pieces, twelve were discarded for reasons that they were either quantitative in nature or were not research articles. The literature search resulted in eleven articles which were accessed and reviewed in 2018-2019. Four studies were based in the UK, three from

Australia, one from New Zealand, one from Austria and two from Canada. Australia, New Zealand and Canada provide health care systems and processes similar to that in the UK therefore they are included within this literature review as their findings could be transferrable to the UK maternity service. Findings from the aforementioned studies shall be discussed. As there are limited published studies based within the UK on the experiences on maternity staff when working with the BFI, it immediately identifies a gap in the literature. On occasions the BFI shall be referred to as BFHI due to the studies which have been included from other countries. A second literature search update was performed at the beginning of 2024 with the same search terms and date range 2018-2023. The purpose of this second search was to identify any UK based research that had been published since the 2008-2018 search. In total of 101 results were found, once duplicates were removed it resulted in 62 articles, none were deemed relevant for this study and therefore have not been considered for inclusion here. Papers published in different countries were excluded in this second literature search as UK based research was being sought.

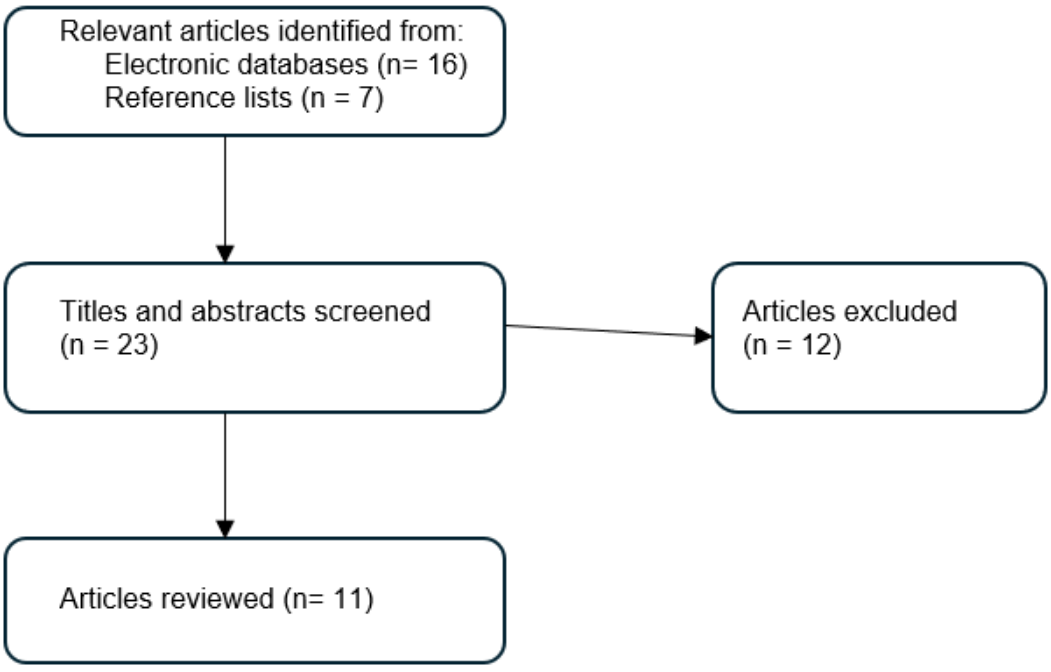

Figure 3 Initial literature search for 2008-2018

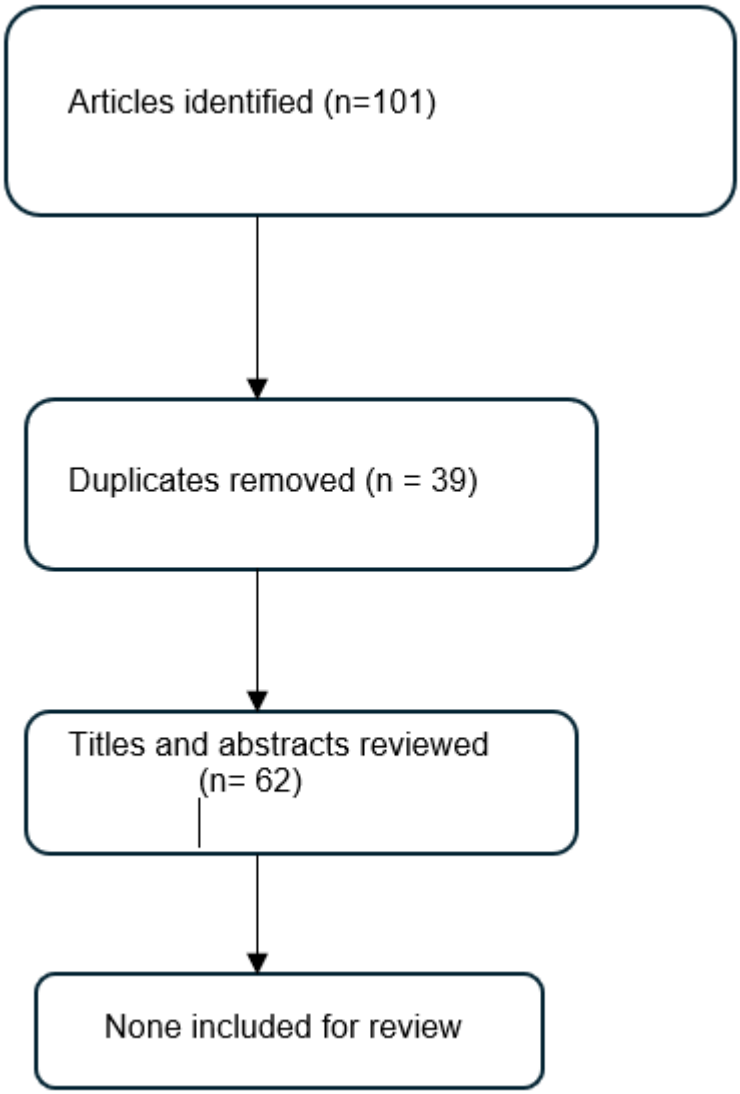

Figure 4 Literature search performed January 2024

4.2 Review of research studies

Table 1 Review of research studies

Year and country of study	Methodology, aims and objectives	Findings	Recommendations and conclusions
Study 1 2006 Furber et al UK	Qualitative grounded theory. In-depth interviews, 30 participants **Aim** = to discover the views of midwives in relation to baby feeding A lot of talk of how midwives act in relation to formula – is that highlighting UK culture? Volunteer nature may have resulted in participants who had something to say -same as my recruitment	Overall category of 'Breaking the rules', then two areas where this applied: 1 – Policy: ○ Rule breaking and policy: Midwives used strategies that were contrary to practice espoused by policy such as formula bottles given to breast fed babies knowing it was not evidence-based care, the bottles were given secretly at night for mother to rest, this behaviour is 'covered up' in case peers or other parents might judge, given at mothers request due to the conversation being facilitated so that the woman suggests it, this 'protects' the midwife from a litigation view ○ Ignoring policy recommendations – Midwives ignored policies of they did not	Participants all declined to be observed in practice, they went to great lengths to cover their rule breaking behaviour due to complaints and litigation. Women should always make an informed choice and give consent to formula, midwifery cultural background is not always conducive to providing woman-centred care. Practice can be knowingly concealed. Behaviour may not adhere to evidence based guidelines.

		agree with them, policies were felt to not support women's choice. 2 – local cultural practices Rule breaking in relation to local culture – keeping secret stash of formula or asking support workers to have some available, staff would ring NCT for assistance, midwives give their personal numbers to women	
Study 2 2007 New Zealand Moore et al	Qualitative study of 6 LC's, interviewed via telephone and taped. **Aim**= to explore the processes and challenges of implementing national policy at hospital level, with a particular focus on steps one and two of the BFHI. **Strengths** = transferable to the UK **Limitations** = participants were LCs – not routine in UK but could be applied	Content analysis enabled theme development= 8 themes: 1. BFHI policy development-policy developed for staff based on BFHI principles 2. Relationship between hospital and governmental policy 3. Communicating policy to staff and change took time 4. Overcoming barriers to communicating policy – management support makes a difference, support includes education for staff and time for training, 5. Difficulty in achieving national BF rates due to complexities of women	**Conclusion** = policy implementation is a multifaceted, staggered and slow process which is typically a government directive not a hospital directive. As BFHI accreditation is not driven by the hospital, external motivation to become Baby Friendly is necessary which includes resources and staff incentives. To ensure that education is far reaching and accessible to all staff, considerable effort and resources are required.

	to maternity support workers with infant feeding roles	6. No regular audits 7. Communicating policy to other providers of health care 8. Size of maternity unit affects implementation, smaller is easier	A stable and educated workforce overcomes barriers
Study 3 2011 South Australia Walsh et al 1 of 3 part study, 2nd and 3rd not available	Qualitative, 6 hospitals, face to face interviews, 31 participants **Aim** = examine the attitudes and directives held by hospital staff towards BFHI accreditation/ to examine the factors that are perceived to hinder or promote BFHI accreditation Objectives were not clear Key finding and message from the study is that maternity staff who understand and work with the BFHI regularly, value it, those who	Thematic analysis = 7 themes 1. BFHI understanding differs between participants – viewed as robust and desirable, resources required such as funding to drive it forward. Some viewed it as an idealistic reward 2. Preconceptions and mothers choice – BFHI principles provide clear direction for staff. Staff from non-accredited units called others bullies, breastfeeding nazis 3. BFHI accreditation process – those not accredited was due to cost decisions, having management support and directive resulted in successful accreditation 4. Intra-organisational difficulties in achieving accreditation – where executive management teams did not have full	Study concluded that maternity unit managers must fully understand BFHI accreditation and approve funding for the completion of the initiative. A breastfeeding policy and new ways of practicing need to be developed and clearly communicated to staff to ensure effective delivery. Whilst it was recognised that breastfeeding initiation rates were good, it was known that these rates dramatically decrease post discharge, Involving the wider population in supporting and promoting

	misunderstand it must make an effort to understand it **Strengths** = provides findings and recommendations that can be transferable to the UK **Limitations** = authors do not state any but all participants were potential stakeholders in the BFHI and so could be viewed as having bias towards their own professional agendas	understanding of the BFHI staff felt lack of support. BFHI lead was key 5. Implementing the steps – staff unaware of scientific evidence, mandatory training is important but can be difficult to implement. Antenatal preparation makes postnatal care easier. Peer support groups viewed as positive. 6. Bottle feeding culture – inhibits support for breastfeeding, some have no exposure to breastfeeding 7. Staff were successful at increasing initiation rates but had lethargy and fatalism as they knew rates would drop after discharge	breastfeeding in the community setting was concluded to be of benefit as community and governmental support are necessary for success of BFHI. 9 recommendations 1. National strategy from governments and expert group to support managers and staff 2. BFHI lead co-ordinator who is supported by leaders 3. Supporting women's choice whilst supporting breastfeeding 4. Policy templates to help with developing policies 5. Resources required – management and staff training

			6. Sponsor staff to be LC's as they are beneficial resources (Moore et al demonstrate benefit of having LC's) 7. Increase breastfeeding education in the community 8. Expand breastfeeding friendly workplace programme to support returning to work 9. Monitor breastfeeding rates and regular internal audits to inform where changed need to be implemented.
Study 4 2011, South Australia, Schmied et al,	Qualitative, interpretive study **Aims** = 1 – elicit the perceptions of midwives, nurses and clinical leaders regarding BFHI	Thematic analysis = 3 themes 1. Belief and commitment – participants believed in the BFHI and were keen for accreditation. The view was the BFHI will	**Outcome of aim 1** – participants perceived the BFHI in a positive way and were committed to accreditation. Considered to be an

1 author was UK based	2 – examine factors that may facilitate or hinder BFHI implementation 128 participants, focus groups **Limitations** = Convenience sample so it does not account for bias, participants limited to interested parties who were available on the day scheduled for focus groups **Strengths** = transferable to UK and findings similar to my study		benefit women and babies due to health benefits of breastfeeding. As with Walsh et al. 2011 – AN education was felt to prepare women resulting in positive experiences. BFHI would provide staff with information to educate women as it is correct and evidence based, this will result in happier staff and will ensure previous wrong information can be corrected without making it obvious to women 2. Interpreting BFHI – 2 opposing views highlighted. BFHI seen by some as delivering key message of benefits of breastfeeding and potential to promote global benefits although concerns were raised about it being misinterpreted. Others felt it was forced onto women and staff. Schmied et al recognised a dichotomy between women's choice and best practice. Women were deemed to being placed under pressure when the BFHI was rigidly applied. Not 'allowed' to give formula to	essential set of clinical practices with positive benefits for women and babies both locally and globally. Staff education was required to ensure it was not interpreted incorrectly. **Outcome for aim 2** – apparent inflexibility of the BFHI was a potential barrier. Likely to be adopted into practice if there are observable benefits Walsh et al study discussed mothers going to staff training to show the 'observable benefits' of the BFHI. Some felt it to be complex (this was ten steps). Organisational support required to ensure staff have time to implement rather than other tasks such as bed block. Some viewed it as a savour, others as another task to add to their list

		help women keep going, this was viewed as BFHI too rigid. As with Moore et al a global strategy for promoting and supporting breastfeeding was discussed but takes time for change. 3. Climbing a mountain – a shift in attitude and views about breastfeeding would be needed among staff, women and community (socio-political). Formula milk used as quick fix but recognised spending time in the first days would save time later. Participants do not have time to sit with women for prolonged periods of time. Resistant to accept BFHI as taking them out of comfort zone, providing them with consistent and repeatedly with evidence based information would allay their fear.	of other clinical priorities. Significant cost associated with implanting it so a cost benefit analysis was needed
Study 5 2011 UK Brown et al	A qualitative descriptive design with the aim to compare healthcare professionals' and mothers' perceptions of the factors that	Content analysis was applied to participants transcripts, five overarching these were identified, categories were then developed within the themes. The themes and categories are as follows:	**Conclusion** = Practical, hands on support and emotional guidance from professional is both valued by mothers and associated with increased breast feeding duration.

	influence the decision to breastfeed or formula fed an infant. Sample numbers: Professionals: 20, Mothers: 23. **Limitations** = The sample of professionals were purposively selected however some declined due to feeling the study lacked relevance for them or there were time constraints on them. Those who did respond to the invitation/participate may have been motivated to promote breastfeeding. The sample of mothers were from a range of socio-economic background and were self-selected, there is a question that those who chose to participate did so potentially due to a personal negative experience of breastfeeding.	1. **Formula feeding as the norm** – Both mothers and professionals raised that bottle feeding has become the 'normal' way to feed an infant in the UK. Some mothers had little experience of breastfeeding prior to making their personal feeding decisions and may have internalised formula feeding as the norm, professionals stated that bottle feeding was integrated in UK society and breastfeeding was almost viewed as abnormal behaviour. Knowledge and understanding of breastfeeding amongst mothers was low with comparisons being made between the behaviour of breastfed infants and formula fed infants, this was discussed by one professional who discussed that seeing breastfeeding in public in the UK was unusual and therefore there were no positive role models for new mothers. Formula milk was felt to be an accepted choice, with mothers who breastfed feeling that they were in the	**Recommendations** = More resources need to be directed to professionals to impart the knowledge and support they are both capable and eager to give potentially increasing both breastfeeding duration and the health of infants and mothers.

		minority with the majority of their friends and family using formula milk, a trigger to stop breastfeeding was lack of support from others. 2. **Breastfeeding and body image** – Breastfeeding was felt to have a negative impact on maternal weight and body image. Professionals felt that mothers choose to formula feed due to the immediate consequences of breastfeeding to their bodies, such as breastfeeding changing the shape and function of their breasts, these changes and the long term effects of breastfeeding encouraged formula use. Mothers reported feeling embarrassed by body changes when already conscious of their appearance following giving birth. Formula was used over fear that breastfeeding would leave breasts misshapen and unattractive. Both professionals and mothers raised that issues of embarrassment such as breasts	

		being sexual and for the mothers' partner rather then the infant impacted the decision of mothers to breastfeed. 3. **Formula feeding as convenient** – the impact of breast or formula feeding were discussed within this theme. Formula feeding was regarded as less demanding on maternal lifestyle, less time consuming, more regular and infants who were formula fed being more settled. Professionals confirmed these ideas by stating that these factors are often attractive to new mothers as their day to day lives could be organised and predicted. Formula feeding mothers believed that formula fed babies were easier, more settled, slept for longer, fed less frequently and were generally more content, some mothers expressed pride in these 'positive' sides of formula feeding believing that encouraging longer periods of sleep was helping their infants. **Other people can give a formula feed to the**	

		infant – Professionals had a strong perception that many mothers chose formula so that they were not solely responsible for feeding their infant, with others able to care for the infant. For the mothers, this meant they could complete other tasks, have a break from exhausting infant care and allowed the opportunity for other people to share in the care of the infant, although this could have been viewed as pressurising the mother into letting them do so. 4. **Breastfeeding as difficult** – Formula feeding was viewed as being simple and with no difficulties, in comparison breastfeeding was believed to be difficult. Professionals highlighted that lack of knowledge and understanding of breastfeeding supported the beliefs that it was difficult, they also felt that mothers were not equipped for the realities and problems that may occur with	

		breastfeeding, along with not understanding where to access help and support in the face of problems. 5. **Anxiety and breastfeeding** – Lack of confidence. This theme was closely associated with theme 4 above, low levels of confidence with breastfeeding and use of formula were associated with each other. Fears of breastfeeding mothers were not producing enough milk, that breastfed infants fed too frequently in comparison to formula fed infants and their infant was not growing fast enough. Mothers discussed the emphasis that was placed by professionals, friends and family regarding infant weight gain which led to anxiety about how much their infant fed and weight gain. Milk supply was doubted and they were not comfortable with not being able to see how much their infant had consumed. Breastfed infants were viewed as being difficult to feed whereas mothers could coax	

		their bottle feeding infants to feed more, resulting with them being 'fuller', with a subsequent increase in weight gain which resulted in mothers feeling proud and secure with their infants growing well. Separate from the main findings, ideas were raised as to how to increase breastfeeding duration. These included: how to encourage the initiation of breastfeeding and support longer breastfeeding duration and the role professionals could play in these factors. These ideas centred on viewing breastfeeding as the normal and accepted best way to feed an infant, increased support was also required. Professionals believed that more support was needed and they were keen to provide this but lack of time and funding were reasons given as to why this support could not be provided	
Study 6 2012 Canada Semenic et al	An integrative review which is a systematic process of a general review of existing literature	Article distribution was 28% USA. 15% Australia and 13% UK. 3 themes – 1) Organisational factors, 2) Individual factors and 3) Socio-political.	Organisational facilitators – Having well co-ordinated change management systems with strong support, mandatory education available for staff

	45 articles from 16 countries included in review, Cooper 5 stages of integrative research review guided review methods To the authors knowledge there was not a comprehensive review of published literature on factors influencing BFI implementation **Objective** = to identify and synthesise information, published in the literature (between 1995-2011), about the barriers, facilitators and recommendations related to the implementation of the BFI	1 – Organisational factors accounted for the majority of barriers and facilitators to the BFI. These related to: o strength and style of leadership of the implementation process –organisational culture, o lack of availability of resources –insufficient funding and inadequate staffing to provide support and attend education, no audit and feedback mechanisms, presence of policies, o no availability of mandatory breastfeeding education – for all maternity staff, o impact of hospital infrastructure of mother-baby contact such as no rooming in and separation and reliance on free or low cost formula. 2 – Individual factors that influenced BFI implementation were: o staff level of knowledge and skill in breastfeeding being inadequate and outdated,	Individual facilitators – access to education and skills training, availability of peer support, innovative strategies to provide women with breastfeeding education Socio-political facilitators – strong recognition of and support for BFI by governments and other professional bodies, enhancing health care provision across the continuum, promote collaborative approaches to BFI implementation Recommendations o Health policy makers to integrate the BFI into national policy and standards of practice.

		○ attitudes toward breastfeeding in general or the BFI specifically- this was the most commonly cited barrier relating to resistance of changing routines and practice, unfavourable opinions of the BFI being too dogmatic or time consuming ○ reluctance to promote breastfeeding out of concern of making women feel guilty or respecting cultural beliefs. ○ overusing formula and bottle-feeding paraphernalia and an absence of sanctions for inappropriate formula use ○ Inadequate antenatal breastfeeding preparation and inconsistent breastfeeding information provision 3 – Socio-political factors related to broader contexts of BFI implementation include: ○ Degree of government endorsement and support of the BFI ○ Extent of integration of health care services ○ Societal norms for infant feeding	○ Establish BFI co-ordinators and formal monitoring systems for breastfeeding rates and practices ○ Implement social marketing strategies to shift public attitudes toward breastfeeding ○ Adopt effective change management strategies by securing resources and leaders for the BFI implementation process ○ BFI education has a central role ○ Create collaborative networks

		○ Strength and visibility of formula marketing practices ○ Enactment of legislation to protect and support breastfeeding ○ Socio-economic status of the health care facility and the populations ○ Adequacy of formal breastfeeding education in health professionals education ○ Aggressive marketing techniques of formula companies ○ Feeding norms that favour formula feeding and are derogatory towards breastfeeding proponents	
Study 7 2013 Canada, Nickel et al	Multisite, descriptive study at 8 hospitals who were participating in a project which is an intervention aimed at supporting maternity units to implement the ten steps. 34 participants, face to face interviews	Organisational readiness has two dimensions: 1 – Collective commitment ○ Refers to whether members of an organisation collectively value the proposed change. 2 – Collective efficacy ○ Refers to the shared perceived ability to organise the resources and cognitive	**Conclusion** - Change requires co-operation of all staff members. Attitudes and beliefs of staff can change with influence from their colleagues – if they believe other are committed they are more likely to become committed. Recommendation – Maternity units planning on implementing the

	Aim = to explore factors which may influence a hospitals readiness to implement the 'ten steps' **Objective** = to apply an organisational level theoretical paradigm to identify and explore factors that may impact 'ten step' implementation efforts **Strengths** = multisite allowed for comparisons and contrasts **Limitations** = Authors felt only 8 hospitals was a limitation but findings can be generalisable and applicable to UK. Possible bias of participant and providing answers they feel authors want. Participating hospitals may have already identified these factors before the study, authors state they may not be generalisable however they are generalisable to my study.	abilities necessary to embed the proposed change. Codebook used to interpret data. Findings categorised as collective commitment, collective efficacy and combination of both. 1 – Collective commitment o Night vs day shift – attitudes, belief and practices between these staff varied. Day staff more committed to BFHI. Night staff did not want to spend the time with women, staff would take baby out and give it formula even when woman made it clear she wanted to breastfeed, there were no consequences for these actions o Management support – very influential on collective commitment. They ensure staff attend training annually and discuss BFHI at yearly appraisals. When managers enforce training and demonstrate commitment – staff will be committed	BFHI/BFI may benefit from assessment of organisational factors in order to target them. Collaboration of maternity staff is required for successful implementation.

		○ Change champions – staff who support BFHI can be influential and should act as change champions, they should discuss the benefits of breastfeeding and importance of evidence based support ○ Observing mothers utilising support – staff become more committed to BFHI when the see women accessing support, it demonstrates that breastfeeding is important to them which aids with staff realising that their care and BFHI does make a difference 2 – Collective efficacy ○ Staffing – Lack of staff affects ability to implement BFHI as they have no time due to 'juggling' lots of tasks and a high workload, staff need more help (band 3's) ○ Training – ability to give support was dependent on mode of training. Hands on training, in this sense, being in a position to view support being provided by other staff, reading and guidance was important but	

		watching felt to be best before needing to refer on. o Visitors – visitors may inhibit women from initiating breastfeeding, baby gets passed around, women felt uncomfortable feeding with family present either for fear of looking inadequate if the baby subsequently did not feed or did not want to face older generations who were encouraging of formula milk. 3 – Combination of both – 4 factors o Attitudes, beliefs and experiences of staff varied by age and work experience – Younger staff (with less than 10 years experience) were found to be more committed to implementing BFHI as they find them beneficial to women and staff, they are viewed as ready to learn. Older staff were felt to be 'stuck in their ways' and doing 'what works'. Those with 15 years or more experience held influence in the unit and the ability to implement BFHI	

		decreased as they do not recognise the benefits of breastfeeding compared to formula feeding and tell women that it did not matter if the baby had formula, without providing evidence. o Perception of forcing versus supporting breastfeeding. Staff have a commitment to respecting women's choice and did not want to 'force' breastfeeding. Staff would not provide breastfeeding information to those who had not made a decision. BFHI seen as supportive by some. Those who were committed to the BFHI found it enabled them to complete their feeding role. o Perceptions of women's cultural beliefs – staff believed cultural beliefs were more important than the BFHI benefits. o Reliance on lactation consultants – there was higher commitment to BFHI when there were 'expert' staff available to assist. There were occasions where women refused help	

		from maternity staff as they did not have 'expert' title – in this case managers stated that staff needed to take more responsibility for breastfeeding support (Sue says about refusing)	
Study 8 2015 Austria Wieczorek et al	As with previous articles that have been reviewed, this has been included as the healthcare system is similar to the UK. Qualitative study, semi-structured interviews. 36 participants. **Aims** = 1- to investigate why BFHI accreditation rates are low in Austria 2- what factors or barriers can significantly influence BFHI implementation in Austrian hospitals **Objective** = to illuminate the perceptions of maternity staff regarding	Thematic analysis Findings presented in 3 themes of selection, installation and facilitators and barriers to BFHI operation. 1 – Selection – two factors emerged that related to whether a unit will proceed with the BFHI or not: o Motives – marketing tool as a means to gain publicity for the unit, having accreditation was felt to be a credible quality label meeting high expectations of women. Set unit apart from others. To improve existing services. BFHI enables paradigm shift to enabling women to care for baby rather than staff taking role of care giver. Improves collaboration between	For maternity units to become accredited with BFHI there is a complex interplay of factors for which planning and preparation is beneficial. External support and government initiatives are essential for successful implementation

	selection, installation and operation of the BFHI 3 hospitals, 2 were accredited, 1 in the process. **Limitations** = authors stated it was in one area only with participants having only positive perceptions of BFHI and personal interest in the study.	professional groups. Expected to change practice and patterns of collaboration. o Promoters and decision making – Individual staff became BFHI change agents who promote the initiative, they were personally convinced of the content and advantages of the BFHI and the benefits it can bring to the maternity hospital. Change agents influenced managers and colleagues. 2 – Installation – 3 factors emerged regarding installation of the BFHI: o Project management – project groups were responsible for the accreditation process. In situ to focus on audits and staff training. Staff commitment was necessary. o Development and dissemination of new standards and training for all health care staff – new standards developed to reduce risk of failures in routine care. BFHI regularly discussed in team meetings. Mandatory innovation that all staff must	

		follow. Mandatory staff training implemented ○ Facilitators and barriers to successful BFHI operation– 3 facilitators and 8 barriers highlighted. ○ Facilitators – 1) staff with BFHI skills and having 'expert' staff such as LC's. 2) Management support and 3) committed staff. ○ Barriers – 1) lack of time and resource. 2) Increased workload. 3) Outdated staff practices with staff resistant to change. 4) Personal staff experiences and tension between own feeding experiences and BFHI principles. 5) Lack of staff 'buy in' specifically medical staff. 6) Interprofessional discontinuation of BFHI care chain during handover of care or shifts changing. 7) Language and literacy barriers. 8) Expectations of women and relatives – formula culture	

Study 9 2016 UK Morris et al	Analysis of comments made on news media websites and parenting forums over a period of 6 months in 2015 which were in response to a widely reported incident, where whilst in a British luxury hotel, a breastfeeding mother was asked by staff to cover herself with a napkin as she breastfed her infant. Appears to be mixed methods as thematic analysis and interrater reliability using Cohen's Kappa was applied to the research but this was not explicitly stated by authors **Aim** = to capture the UK community's opinion on breastfeeding in public by analysing public responses **Objective** = to understand why some UK residents object to this practice	Comments were thematically analysed and categorised into three themes: 1. "Always acceptable" – Breastfeeding in public is always acceptable 2. "Acceptable with discretion" – Woman may breastfeed in public but need to exercise discretion. 3. "Not acceptable" – It is never acceptable to breastfeed in public. There were 7 themes presented in the published article but only 4 were discussed, these are: 1. **Discretion/breastfeeding etiquette** – this was split into a further 3 subthemes of: ○ **"Respect for others"** - breastfeeding mothers should have respect for other people's sensibilities and place the interest of others over her own and her infant by being discrete and/or covering up while breastfeeding in public due to the concern of nudity and other people not wishing to see those with their "nipples out". There was a feeling	**Conclusion** = Although the authors state that their sample may not be generalisable to the UK population, they concluded that observance of breastfeeding etiquette appears to be critical for public acceptance. **Recommendations** = Campaigns which highlight that human milk is food rather than a bodily fluid and to normalise breastfeeding in public may be beneficial in addressing objections.

	Strengths = The research method has "proven powerful to generate as-of-yet unreported practical insight into a challenging topic". **Limitations** = the sampling method was stated as the main limitation and it "is impossible to generalise the views to the UK population". A lack of information about the commenters made it impossible for the researchers to know which segments of society had these opinions	amongst some that breastfeeding mothers feel they are entitled and have a privilege over others ○ **"It's ok not to look"** – comments included that it was ok not to look at a breastfeeding mother and it is not a rude action. ○ **"Don't know where to look"** – some were afraid as they did not know where to look in case they were caught accidently glancing and a suggestion was made of "why not be nice and cover up instead of making many more people feel uncomfortable in case they are called a pervert" 2. **The breast as a sexual object** – this perception was commented on by the majority of those who supported breastfeeding in an attempt to explain why their opponents held negative views and discussed how female nudity is acceptable in other contexts in the media but	

		breastfeeding is not ok, especially when the breasts are being used for their function and intention. 3. **Breastfeeding is natural** – that breastfeeding is natural was found to be commented on by supports and opponents. Opponents likened breast milk to other bodily fluids and bodily functions which should not occur in public and gave examples of belching, passing wind and having bowels open in their justifications for opposing public breastfeeding. **The Others** – This theme covers the 'older' culture and male teenagers where commenters discussed how these groups of people may be offended by breastfeeding and cited foreigners, these from other cultures and young people as likely to be offended. Where comments were made by the 'older' generation these were mixed. There were no obvious comments made by teenagers	
Study 10 2017	Historical document analysis, 1992-1995 these dates covered the time	Content analysis – 4 themes identified:	It was optimistic of UNICEF to assume or hope that governments

Australia Atchan et al	frame of recommended and actual implementation timeline. **Aim** = to examine the introduction of the BFHI into the Australian setting **Strengths** = access to a wide range of documents **Limitations** = old date range although findings are still applicable	**1.** A breastfeeding culture – this encompasses a culture where breastfeeding is the norm and the environment supports women to breastfeed, political and cultural environments: ○ Reporting breastfeeding prevalence and practice – data of breastfeeding trends are essential to inform policy ○ Goals and targets – Goals and targets to increase the prevalence and duration of breastfeeding need mechanisms to monitor progress to assess change in population health ○ Limiting applicability – situating the BFHI and breastfeeding in guidelines that are applicable to the population and staff ○ Supporting the BFHI – clear direction, support and encouragement in polices are required to demonstrate support **2.** Resource implications –	would implement the Innocenti Declaration in full. Challenges to implementation were varied yet interrelated. Recommendations: Have a dedicated committee and ongoing funding to translate evidence into practice, Evaluate progress of initiative, determine enablers and barriers prior to commencing embedding the initiative. Propose an economic model with short and long term projections. Clear policies with incentives Establish goals and targets and measure outcomes

		○ provision of resources to implement and evaluate the BFHI are required, financial assistance essential to achieve implementation, lack of resourcing indicated attitudinal issues **3.** Ambivalent support for breastfeeding and the BFHI – ○ Stakeholders demonstrated ambivalence to the BFHI and breastfeeding support. Lack of clear policy and direction suggested a sense of ambivalence. **4.** Advocacy versus business – ○ There were tensions between advocacy and business, funding requirements were not appealing to policy makers	
Study 11 2017 UK Grant et al	Mixed methods methodology. Cross-sectional online survey of infant feeding coordinators by utilising a pre-existing survey instrument which	Structured into 4 sections: 1 - A description of respondents (n=136): ○ Respondents were infant feeding coordinators (n=47), Breastfeeding	**Conclusion**: A peer support model that is effective in improving UK breastfeeding rates has not been established. Where there is peer

	included open ended and closed questions. Closed question responses were generated using statistics software, open ended question responses were thematically coded, with themes being generated both inductively and deductively. **Justification** = an understanding of current practice is required to asses what can be delivered in regards to peer support, the challenges of implementing this form of support and to inform service development. **Aims** = **1** – to describe the coverage of breastfeeding peer support services and breastfeeding support groups **2** – to describe models of peer support provision **3** – to identify/describe facilitators and barriers to implementation **Limitations** = Due to a lack of definition between the terms peer	coordinators (n=10), remaining respondents had job titles which focussed on infant feeding. No responses from academics. All responses accounted for 58% of NHS organisations in the UK. Breastfeeding peer support was available in 56% of organisations, breastfeeding support was available in 89% of organisations, there was a high degree of overlap noted in these two groups. There were 5 areas (3%) where neither of these groups were present. 2 - The management and delivery of breastfeeding peer support services: o Infant feeding coordinators were involved with management of peer supporters with some voluntary groups being part of a team delivering peer support. A multi-strategy approach of professionals	support provision, it is variable. High quality breastfeeding peer support training can increase knowledge of breastfeeding. There did not appear to be uniform standards for training of peer supporters. There was no standardised breastfeeding support provision in the UK and services were adapted in line with available funding rather than the number of births in the area. **Recommendations** = 1 - Clear roles and guidance enhance cohesion and should be considered in the development of peer support services. 2 - Perceptions of breastfeeding groups and breastfeeding peer supporters as a source of pressure to breastfeed require addressing.

	support and breastfeeding group, this may have led to variations in meaning between respondents. The survey questions were felt to be theoretically susceptible to bias and were available for 3 weeks, the authors felt if the survey was open for longer they may have received more responses. Two participants were unable to access the online survey.		and peer supports were involved with recruitment of new peer supporters. The most popular peer supporter training was delivered by groups including the Breastfeeding Network and the National Childbirth Trust. 33% of respondents stated that training was variable in relation to content and duration. There was some vagueness regarding training, it was more accessible in some areas, it was absent in others and was provided as joint training in some areas. The main activity of peer support workers was attending breastfeeding groups, although they did not organise them. This was closely followed by them working within the postnatal ward. Group support was more common than one to one. There was variety in them providing support either	3 - Breastfeeding services should reach out to mothers from deprived areas. 4 – Routine record keeping would enable effective monitoring of service usage which may support with financial investment in the future. 5 – Further research is required to investigate new models of breastfeeding support which has been developed in conjunction with mothers and health professionals.

		antenatally, postnatally or on both periods. Peer support was felt by 63% of respondents to be integrated with NHS services such as maternity and health visiting services, where this was successful there was clear guidance on roles and responsibilities, shared working practices and locations and a high degree of trust. It was felt that mothers from poorer social backgrounds accessed the support service the most although some services had been commissioned in deprived areas. Barriers to accessibility included inadequate numbers of peer support workers, lack of attractiveness to women from deprived areas, being reactive as opposed to proactive and the inability to provide home visits.	

		3 - Management and delivery of breastfeeding support groups: o These groups took place in a range of settings including community venues such as cafes and children's centres alongside weighing clinics and were organised by NHS staff, children's centre staff and trained peer supporters. The focus of these were predominantly breastfeeding rather than breastfeeding support groups. Comprehensiveness of record keeping varied over sites. 4 - The impact of resources on service delivery: The importance of financial support for community breastfeeding services was a main theme throughout the open responses. It was problematic to many has funding has been restricted and the NHS was no longer funding peer support services. There is no longer funding to provide training, pay travel expenses or resources for supervision by	

		health professionals. Some services were attempting to secure funding from charities to continue peer support services. Lack of funding has led to frustration amongst respondents.	

The first article reviewed is UK based, it could be considered outdated owing to being published in 2006, however it has been included as there are findings that are applicable to this PhD study. The aim of Furber et als (2006) research was to discover the views of midwives in relation to infant feeding, 30 midwives volunteered to participate. The voluntary nature is likened to the participants in this study who may have had their own agenda or felt they had 'something to say'. Participants in Furber et als (2006) study consented to in depth interviews but declined observation of their clinical practice. The main category for the findings was labelled 'Breaking the rules' which was divided into two subcategories of policy and local cultural practices. The theme and discussion of the article was on the topic of formula and how midwives are 'breaking the rules' of both policy and culture. Midwives admitted that they actively ignored BFI or infant feeding policies as they either did not agree with them, or they felt that women's choice was not supported enough. Practises such as providing bottles of formula milk to breast fed babies for mothers to rest were given 'secretly' and only throughout the night with some midwives hiding their own supply of formula or providing their personal phone number to women as a point of contact for support. The conversation between the women and midwives would be orchestrated so that it appeared to be 'maternal choice' to provide formula, this was to provide a 'protective' element to midwives practice and behaviour due to fear of complaints and litigation. Furber et al (2006) concluded that women should always give consent for formula use following an informed choice and that midwifery care can be concealed and not always conducive to woman centred care, infant feeding behaviours are not always in line with evidence.

The second study in the review was published in 2007 and based in New Zealand (NZ), six lactation consultants (LCs) were interviewed. The aim of the study had focus on only steps one and two of the BFHI rather than the full initiative, Moore et al (2007) aimed to explore the processes and challenges of implementing national policy at hospital level. The findings highlighted that BFHI policies needed to be developed based on all steps included within the BFHI. Once this had been completed it was essential to communicate the policy to all heath care providers, although it was recognised that for completion of this stage and for change to become incorporated it would take time. There is a requirement for a

relationship between hospital and government policy and any barriers in overcoming communication of the policy would require managerial support, support packages would include education for staff and time provided for staff to attend the training. Moore et al (2007) identified that challenges also included a lack of regular internal audits, although it was recognised that there were difficulties in achieving and collecting national breastfeeding rates due to complexities of the population. The final finding highlighted that the size of the maternity unit had an impact on BFHI implementation and that the process was deemed to be easier in smaller units. When BFHI implementation is driven as an external governmental directive, the process can be multifaceted, slow and staggered, considerable effort and resources are required with a necessity for external motivation which includes provision of resources and staff incentives. Having a stable and educated workforce aided in overcoming barriers to BFHI implementation. It was felt that the findings of Moore et als. (2007) study can be transferable to the UK and applicable to the PhD study, in this instance the band three support workers at the study site could be viewed as having similar roles to that of LC's.

Walsh et al. (2011) examined the attitudes and directives that were held by hospital staff towards the BFHI and examined the factors that are perceived to hinder or promote BFHI accreditation. They interviewed maternity staff, findings were identified from theme development. Walsh et al. (2011) found that BFHI understanding differed between participants, whilst it was viewed by some as robust and desirable other participants viewed it only as an idealistic reward. As found and recommended by Moore et al (2007), Walsh et als. (2011) participants stated that resources such as funding was required in order for the programme to be implemented. A clear breastfeeding policy and new working practices must be communicated to staff (Moore et al. 2007; Walsh et al. 2011) alongside mandatory staff BFHI education and training. The study by Walsh et al (2011) was completed in Australia however it had the same findings of the 2006 study by Furber et al. in the UK where a strong formula feeding culture was present within the maternity units, there was also the suggestion in both Furber et al (2006) and Walsh et als. (2011) study that the BFHI was not always supportive of women's choices. The recommendations from this study included the need for

a national strategy from government, this was also a recommendation from Moore et al (2007), funding for leaders who support the BFHI, along with resources to supply staff with education and training. Breastfeeding rates to be monitored regularly in the community and regular internal audits within maternity units to inform where change needs to be implemented. Where recommended, women's choice is to be supported whilst also supporting breastfeeding, with an increase in breastfeeding education in the community and an expansion of the breastfeeding friendly return to workplace programme (Walsh et al. 2011).

Schmied et al (2011) completed a study in Australia in the same year as Walsh et al. (2011). There were two aims of their study which were to elicit the perceptions of maternity staff regarding BFHI and examine factors that may hinder or facilitate BFHI implementation, this second aim is almost verbatim of Walsh et al (2011). Their interpretive study resulted in three themes for their findings. Schmied et al (2011) developed findings that differed slightly to the three previous studies in this review, their participants had faith in the BFHI. They believed it benefits women and babies and provides staff with the correct evidence-based information for them to support women, it offers the opportunity to correct wrong information being provided and therefore prevents confusion or conflicting advice. Participants were keen for accreditation status for their hospital. There were opposing views regarding interpretation of the BFHI, it was seen by some as delivering key breastfeeding messages and the potential to promote global benefits although there were concerns about it being misrepresented. There were feelings of it being forced onto women and staff with a sense that women were being unduly placed under pressure when the BFHI was applied rigidly, an example provided was maternity staff not being 'allowed' to give formula to breastfed babies to 'help women keep going' (Schmied, et al. 2011). Schmied et al. (2011) and Moore et al. (2007) both highlighted that a global strategy was required to promote and support breastfeeding but that change takes time. There is a shift in attitude required amongst maternity staff and the community. Formula milk being used as a quick fix is recognised as impacting on care in later days and participants do not currently have time to sit with women for prolonged periods of time to support breastfeeding. There was a resistance among some participants to accepting the BFHI as they felt it would

be taking them out of their knowledge comfort zone although it would be providing them with consistent evidence-based information which would allay their fears.

The outcomes for aim one were that the perceptions of the BFHI from participants was positive and they were committed to accreditation, the BFHI was considered to be an essential set of clinical practices with positive benefits for women and babies. Staff education was also recommended in this study to ensure it was not interpreted incorrectly; this has been a recommendation in most studies that have been reviewed (Moore et al. 2007; Schmied, Gribble, et al. 2011; Walsh et al. 2011). Factors which were identified as facilitators were organisational support to ensure staff have time to implement the BFHI and it was viewed as a 'saviour' when providing feeding support. Factors which are viewed as hindering the implementation are that participants felt it to be complex with too many 'steps' to follow and therefore another task to add to their list of clinical priorities. There was acknowledgement that implementation would be associated with significant cost, Moore et al. (2007) and Walsh et al. (2011) both recommended funding provision from the government to support implementation, a cost benefit analysis was recommended (Schmied et al. 2011).

Semenic et al (2012) completed an integrative review, their rationale being a lack of a comprehensive review of published literature which focussed on factors influencing the BFI implementation. Their objective was to identify and synthesise the published literature between 1995-2011 which relates to the barriers, facilitators and recommendations related to the implementation of the BFI. The article distribution was heavily weighted to the USA (Table 1) however it is felt that the findings and recommendations are transferable to the UK. The review categorised the findings into themes of organisational, individual and socio-political factors. The discussion for this PhD study is also categorised into these three themes. Organisational factors related to strength and style of leadership of the implementation process, availability if resources such as funding and staffing, education, audit and feedback mechanisms and presence of policies. Individual factors which influence BFI implementation were staff knowledge and skills in breastfeeding being outdated, unfavourable opinions and negative attitudes towards breastfeeding and the BFI, reluctance to promote

breastfeeding out of concern of making women feel guilty, overuse of formula and an absence of sanctions for inappropriate formula use and inadequate antenatal breastfeeding preparation. Socio-political factors relate to broader context of the BFI and included the degree of governmental endorsement and support of BFI, clear government strategy was recommended by Moore et al. (2007), Walsh et al. (2011) and Schmied et al. (2011). Societal norms for infant feeding, the strength, visibility and aggressive marketing techniques of formula companies and feeding norms that favour formula feeding and are derogatory towards breastfeeding are all factors which impact implementation of the BFI. Having strong change management systems with mandatory staff education, peer support strategies and breastfeeding education for women are viewed as facilitators for organisational and individual factors. Recognition and support of the BFI by government and professional bodies will promote collaborative approaches to BFI implementation (Moore et al. 2007; Schmied, Gribble, et al. 2011; Walsh et al. 2011; Semenic et al. 2012). Recommendations from the integrative review compare to the studies reviewed here so far. Integration of the BFI into government policies and professional standards, establishing BFI co-ordinators, monitoring systems for breastfeeding rates in the community and the creation of collaborative networks are all recommended to facilitate implementation of the BFI in maternity services.

The studies that follow were published after the integrative review, they will be compared and contrasted with each other and Semenic et al. (2012). Nickel et al. (2013) aimed to explore factors which may influence how ready a hospital is to implement the BFHI, they applied an organisational theory paradigm to identify and explore factors that may impact implementation efforts. The authors felt that there were limitations to their findings however there are many elements which are transferable to the UK and generalisable to this PhD study. The readiness of an organisation was found to have two dimensions; collective commitment and collective efficacy. These relate to whether members of an organisation collectively value a proposed change and to the shared perceived ability to organise the resources and cognitive abilities necessary to embed the proposed change respectively. Collective commitment found that there are differences in attitudes, beliefs and practices between night and day shift staff,

there was formula use through the night which compares to Furber et als. (2006) findings. Management support influenced commitment, when training was enforced and they demonstrated commitment themselves, staff will also demonstrate commitment. Walsh et al (2011) recommended that maternity staff observe women accessing breastfeeding support, this was highlighted in Nickel et als. (2013) study, maternity staff will become more committed when they realise that breastfeeding is important to the women in their care. Collective efficacy related to staffing levels, training and visitors and how these influence BFHI implementation, staff education is highlighted (Semenic et al. 2012). There were also findings which were a combination of both commitment and efficacy and included attitude, beliefs and experiences of staff in relation to their age and work experience, the perception of the BFHI forcing women to breastfeed, an acknowledgement of women's cultural beliefs and over reliance on staff who are viewed as experts in infant feeding support (Semenic et al. 2012; Nickel et al. 2013). Nickel et al. (2013) concluded that change requires the co-operation of all staff members; staff attitudes and beliefs can be influenced by colleagues. They recommended that an assessment of organisational factors prior to implementing the BFI may be of benefit, this appears to be similar to the recommendation of performing a cost benefit analysis (Schmied et al. 2011). Collaboration of maternity staff is required for successful implementation (Nickel et al. 2013).

Wieczorek et al. (2015) investigated why BFHI accreditation rates were low in Austria and identified what factors or barriers can significantly influence BFHI implementation in Austrian hospitals. As with the other studies within this review the findings are deemed to be applicable to the UK. The findings were presented in three themes of selection, installation and facilitators and barriers of successful BFHI operation. Motives of the hospital were a factor, participants felt that accreditation status set their unit apart from others and would improve existing services for women, promoters of the BFI were beneficial and acted as change agents who influenced management and colleagues. A project management approach with committed staff and the development and dissemination of policies and new standards aided with the installation of the BFHI, mandatory staff education was implemented. Facilitators to successful

implementation included ‘expert’ staff with specific BFHI skill, managerial support and committed staff. Barriers that were highlighted are similar to all the studies that have been reviewed here. Lack of time and resources compounded with an increased workload, outdated staff practices with staff resistant to change and tension between staffs own feeding experiences and the BFHI principles were recognised as barrier. Lack of ‘buy in’ by medical staff, interruption of the care chain, language barriers and the expectations of women and their families, specifically a formula culture were also identified as barriers to successfully implementing the BFHI.

The final study included in this literature review is another based in Australia, the authors (Atchan et al. 2017) completed a historical document analysis which included a wide range of literature covering the time span for recommended to actual BFHI implementation in the country, this explains the date range of the documents of 1992-1995. Although seemingly outdated, the findings and recommendations are generalisable and applicable to the UK. The aim of their study was to examine the introduction of the BFHI into the Australian setting. Four themes were identified form content analysis. The first finding highlights a breastfeeding culture which encompasses a culture where breastfeeding is the norm with an environment that support women to breastfeed, they identified that reporting breastfeeding rates and prevalence, identifying goals and targets, ensuring applicability of policies and supporting the BFHI were essential. Resource implications included lack of funding to achieve implementation and where managers allowed for lack of resources it indicated attitudinal issues. Implementation will not be successful where there is ambivalence from stakeholders, documentation that was analysed demonstrated that there were tensions between advocacy and business, funding requirements were not appealing to policy makers. The recommendations for funding (Moore et al. 2007; Walsh et al. 2011; Semenic et al. 2012) would have had relevance here. Atchan et al. (2017) conclude that UNICEF were optimistic to assume or hope that governments would implement the Innocenti Declaration (Atchan et al. 2017) and provide funding, the authors found that challenges to successful implementation, although varied were interrelated. Recommendations provided from this study are embedding the BFHI evidence into practice, continuous

evaluation of the progress of the initiative, determine enablers and barriers prior to commencing embedding the initiative (Schmied, Gribble, et al. 2011; Nickel et al. 2013), propose an economic model with short and long term projections with clear policies, incentives, goals and targets and measurable outcomes.

4.3 Literature review findings

The findings from the literature review have been categorised into three sets of factors: 1) organisational; 2) Individual; and 3) Socio-political factors.

4.3.1 Organisational factors

Organisational factors represented the majority of barriers and facilitators. Implementation was identified as a multifaceted process which was dependent on both supportive and hindering factors (Moore et al. 2007).

A frequently cited finding was that a well-co-ordinated strategy for change management was beneficial. Nickel et al. (2013) have recommended that maternity units who are planning on implementing the 'Ten steps', BFHI or BFI (depending on country), may benefit from an assessment of organisational level factors that may impact collective commitment and efficacy. Once supporting factors have been identified, strategies can be developed to target them, maternity staff can play a vital role both in the identification of barriers and developing strategies to overcome them (Nickel et al. 2013). This is supported by Wieczorek et al. (2015) who state that there is benefit to planning and preparing before the BFHI is implemented.

Applying principles of project management within organisations who were ready for change was identified as a facilitator of implementation (Wieczorek et al. 2015). Walsh et al. (2011) agreed with integrating change yet they discussed that it could potentially be more complex for larger hospitals. Change agents or change champions are individuals who are influential in supporting change; advocates of the BFHI should be in these roles (Nickel et al. 2013, Wieczorek et al. 2015) in both accredited and non-accredited maternity units. Staff co-operation was necessary for successful change (Nickel et al. 2013) and staff supported by management to facilitate the changes that BFHI required (Wieczorek et al. 2015).

The strength and style of leadership throughout the process of implementation was identified as a significant factor, management support was essential. Baby friendly standards and any related issues should be regularly communicated to staff (Daniels and Jackson 2011) with theoretical and practical skills training on the topic of infant feeding practices being provided for staff annually, as a minimum and BFHI support discussed in yearly staff appraisals (Nickel et al. 2013). Walsh et al. (2011) found that there was a lack of support from executive management who often did not understand what BFHI entailed, or that management was unaware of the relationship between BFHI and improved public health outcomes.

For the adoption of the ten steps to breastfeeding to be successful, many articles identified mandatory and flexible breastfeeding education as a vital element. BFHI education was not solely aimed at staff. Maternity units who have achieved BFHI accreditation status were consistent in their information provision to service users and hence better antenatal preparation (Schmied et al. 2011). Antenatal education provides the opportunity to discuss the BFHI and can guide discussions and care in the postnatal period (Walsh et al. 2011). Unaccredited units had no awareness of the current evidence base relating to the BFHI, whilst accredited units regularly update and demonstrate knowledge and skills when providing infant feeding support (Walsh et al. 2011). Daniels and Jackson (2011) found that there was an overall lack of staff knowledge and training. Although in-house education could be helpful, Walsh et al.'s (2011) findings stated that mandatory education was difficult to implement. Alongside robust evidence, personal and professional experiences of infant feeding could be utilised in the development of clinical guidelines or directives for practice (Walsh et al. 2011), these directives should aid with staff commitment to mandatory BFHI training (Nickel et al. 2013). Moore et al. (2007) stated that to ensure staff have access to education which has far reaching benefits, incentives and resources need to be matched with organisational motivation for BFHI policy implementation. Targeted services for women with additional educational needs or who may require translation services should be implemented for those who require it. BFHI principles, if made part of staff daily routines, assisted in implementation (Wieczorek et al. 2015). A change in the practice of health professionals may

result in a change of women's views, breastfeeding should be promoted as the "normal way" to feed a baby (Schmied et al. 2011).

Alongside change agents or champions, there could be incentives for staff to become lactation consultants (LC), LC's are employees with expert knowledge of breastfeeding (Wieczorek et al. 2015). An increase in the number of LC's was found to support BFHI implementation (Moore et al. 2007) yet there were varying levels of commitment to BFHI standards dependent on the role of the LC. In units where LC's were in place to provide additional support and advice in complex cases there was a higher commitment to BFHI, conversely there was lower commitment where LC's provided all breastfeeding support (Nickel et al. 2013).

Inadequate staffing was often recognised as an institutional barrier (Daniels and Jackson 2011 Nickel et al. 2013) by ultimately limiting the direct support provided to breastfeeding mothers (Schmied et al. 2011, Nickel et al. 2013) and the opportunities for staff to attend training. Issues such as a busy workload, high ward acuity and time spent relieving bed block, ensuring that discharges occurred in a timely manner due to an increased demand for the bed to be used for admissions, were all identified as hindering factors to providing feeding support.

Situational factors included variants of rooming in between non-accredited and accredited units. The World Health Organisation (WHO) provides a definition of rooming in as a practice within maternity units where healthy newborn infants are with their mothers in the same room from the moment that they are born until discharge home, the dyad remains together 24 hours a day (WHO 2018). Other situational factors are difficulties encountered with skin-to-skin contact, or lack of, in operating theatres (Walsh et al. 2011), with the infant generally being passed around family members, mothers reluctant to breastfeed in the presence of family/visitors and the likelihood of older visitors to encourage artificial supplements (Nickel et al. 2013).

4.3.2 Individual factors

Individual factors which were seen to impede successful BFHI implementation are personal and professional staff attitudes, beliefs, values and age and personal attitudes of mothers and relatives (Wieczorek et al. 2015). There were

differences noted between older and younger staff and day duty/night duty staff. Older staff were identified as being “stuck in their ways” with less commitment to change. In units where older staff had influence, it was felt there was a decreased ability to implement BFHI, little benefit of breastfeeding compared to artificially feeding was acknowledged as “what they were doing works” (Wieczorek et al. 2015). Younger or less experienced staff members had a higher commitment to BFHI implementation (Nickel et al. 2013). Day staff were seemingly more committed, with the perception that night duty staff were not willing to take the time to support BFHI standards (Nickel et al. 2013). When questioned as to why this was the case, respondents answered that possibly the night staff felt that they would assist in providing the mother with an opportunity to rest overnight, with few, if any at all, recognising the negative consequences linked to supplemental feeds while exclusively breastfeeding (Nickel et al. 2013). Measures that are available to support relationship building were also not recognised, such as the importance of rooming in. A further aspect regarding staff was the professional issue of not keeping up to date with current evidence that supports BFHI, resulting in inadequate knowledge and outdated practice, with those who work in non-accredited units claiming that to be accredited is “just an idealistic reward” (Walsh et al. 2011).

Staff perceived that the BFHI produced a heavy workload (Daniels and Jackson 2011) with the postnatal period viewed as complicated. Some mothers sent contradictory signals to staff regarding their infant feeding choice (Walsh et al. 2011). Staff also felt they had inadequate time available to support women (Schmied et al. 2011). There was also the perception amongst staff that the BFHI was being forced on both themselves and the women in their care, this resulted in negative feelings which ultimately impacted the influence they had on women (Walsh et al. 2011), staff felt there was pressure on women to breastfeed rather than to respect the choices they had made (Schmied et al. 2011, Nickel et al. 2013). Descriptions were given of being mother unfriendly and “breastfeeding Nazis and bullies” (Walsh et al. 2011).

A lack of clarification regarding the medical grounds for supplementation, inappropriate use of formula and reliance on pacifiers and breast pumps were

also seen as staff barriers to effective BFI implementation. Midwives felt that to achieve BFHI status, medical support was essential, differences of perceptions between professional groups needed to be eliminated so that BFHI could be adopted equally (Walsh et al. 2011, Wieczorek et al. 2015). Implementation of the BFHI standards in an organisation resulted in a clear direction for staff to give information and provide evidence-based care (Walsh et al. 2011). Having a clear direction may aid in a change of attitudes and perceptions of staff as it can be problematic for organisations to directly change staff attitudes (Wieczorek et al. 2015).

4.3.3 Socio-political factors

Having governmental and professional body support for breastfeeding and recognition of the BFHI was a facilitator of implementation within some maternity units in Australia and New Zealand. Countries with strong governmental support regarding the implementation of the BFHI have policies and directives in place. Implementation is mandatory in some units (Moore et al. 2007, Schmied et al. 2011). Wieczorek et al. (2015) suggested a lack of government support may explain Austria's low levels of BFHI accreditation.

Collaborative working across maternity organisations and regions improves the accessibility of breastfeeding support and approaches to implementation. To increase compliance rates, interdisciplinary and advocacy groups could assist with dissemination of policies and directives (Moore et al. 2007).

Of the eleven studies reviewed just two (Walsh et al. 2011, Morris et al. 2016) discussed social factors. Walsh et al. (2011) found that peer support groups provided positive support; non-accredited units displayed a lack of support. This study is from Australia where there is a strong reliance on pacifiers within the community as a whole and a formula feeding culture. Infant formula companies and their perceived aggressive marketing practices, lenient government adherence to the International Code of Marketing and societal norms that favour formula feeding were all barriers to successful BFHI implementation.

This literature review provides an integrated synthesis of the eleven studied articles, organised thematically. Barriers to successful implementation of the

BFI were identified across multiple studies and include lack of staff education and training, time pressures, outdated practices and concerns about rigid policies that may limit maternal choice. Common facilitators are strong organisational leadership from midwifery managers and BFI lead staff, availability of adequate resources, collective staff commitment to change and the integration of BFI principles into government policies and professional standards. The benefit of audits and feedback mechanisms to support implementation are highlighted. The barriers are interrelated evidencing the need for collaboration across all staff levels for successful change management.

In conclusion, the chapter provides a synthesis of factors influencing BFI implementation based on existing literature. It identifies consistent barriers and facilitators across international contexts relevant to the UK, supporting the significance of the present study.

Chapter 5 Methodology

This methodology chapter will outline the study design, ontological and epistemological philosophical perspectives and the methodological approach adopted for this qualitative research project.

The aim of the research was to explore the experiences of maternity staff when working with the UNICEF UK BFI standards within a local maternity unit. A qualitative case study design was chosen as the most appropriate for addressing the exploratory research aim focused on understanding staff experiences.

5.1 Philosophical perspectives

5.1.1 Ontology

Ontology refers to the nature of reality, for this study a pragmatist ontology was the philosophical perspective. A pragmatist ontology posits that reality is not a fixed entity, it can be objective or subjective, but it is constantly being constructed and reconstructed through human actions and interaction. Pragmatism brings actions and beliefs together to create meaning from experiences (Morgan 2014). This perspective aligns well with qualitative case study research due to the researcher requiring understanding of the interplay of factors which shape the phenomena under investigation, in this case, the experiences of maternity staff working with the UNICEF UK BFI. The focus within a pragmatist ontology is not to uncover an objective truth but to understand the multiple realities that are constructed by individuals when interacting within social and cultural contexts, which is relevant for the personal and professional roles of maternity staff participants in this study. This ontology also aligns with the emphasis on which case study research is based which is exploring subjective experiences and interpretations of those involved in the 'case'. It has a focus on solving 'real world' problems and addressing the needs of individuals and communities, applying this perspective to research allows for solutions to the 'real world' problems to be 'found'.

Initially phenomenology was considered as the key methodology. Both transcendental and hermeneutic phenomenology did not fit with the aim of the study, which was to explore the experiences of maternity staff, as this approach

analyses what is perceived by consciousness regarding the experiences of individuals (Delmas and Giles 2023). I felt that I wanted to remain true to the voice of the participants about their own experiences and not my interpretation. Classic grounded theory (Glaser and Strauss 1967) was considered however I did not want to generate theories as to the experiences of staff, which ultimately resulted in pragmatism as the ontological perspective. Whilst pragmatism has links to the Chicago School it can be viewed as an anti-philosophical approach as it developed from a practical, problem-solving culture (Williams 2016). The theory of truth for pragmatists is that what practically matters to a person and their beliefs, is what is true, for the researcher the truth is that these beliefs are held by the person (Williams 2016). Pragmatism as a research paradigm has a focus on the research questions and the consequences of the research rather than on the methods adopted, the philosophy holds that actions of humans can never be separated from their past experiences and beliefs which have originated from those experiences (Kaushik and Walsh 2019). Personal and professional experiences of breastfeeding have an impact on care that is provided to breastfeeding mothers, which links to the pragmatist view that thoughts are linked to action. Yefimov (2004) states that a major underpinning philosophy for pragmatism is that a person's knowledge and reality are based on their beliefs and habits which are socially constructed.

5.1.2 Epistemology

A practical epistemology emphasises the importance of experiential knowledge and the process of learning through doing, meaning that knowledge is generated through active engagement with the 'case' under investigation. A practical epistemology was the perspective applied to this study as it rejects the notion that knowledge is a static entity that is merely transferred from one individual to another and views it as a dynamic process that is shaped and reshaped through interactions.

In both of these ontological and epistemological perspectives the researcher plays an active role in the construction and interpretation of knowledge, emphasising the practical implications of research and its relevance to societal concerns. The researchers' experiences, beliefs and values are recognised as

influencing the research process which highlights the importance of reflexivity and the ongoing self-awareness of the researchers influence on the research.

5.2 Theoretical framework

Constructivism is focussed on how individuals construct their own realities, understanding and knowledge of the world via their own experiences, reflections and cognitive processes, resulting in multiple realities (Shannon-Baker 2023). This theoretical framework is a natural fit for this study as it is centred around how staff make sense of a particular phenomenon, in this instance the BFI. Due to the nature of subjectivity and the assumption that multiple realities exist, of which some of these realities are socially constructed, constructivism is justified for my research. Many maternity staff have both personal and professional experience of infant feeding, which will also vary across their socio-cultural backgrounds therefore offering differing perspectives of the same phenomena.

Utilising a constructivist paradigm aids with developing research questions. My study was to explore the experiences of maternity staff therefore I was searching for in-depth rich data from their lived experiences and it was important for their voices and experiences to be understood. As is discussed in the methods chapter, interviews were the main data collection method used throughout this study, the interview guide was developed using open-ended and flexible questions. This allowed for exploration of the participants replies, beliefs and perceptions and for unexpected insights from both myself and participants to emerge during the research process. The use of open-ended questions, ongoing consent and participant validation throughout the interviews meant I could ensure that they felt valued, heard and protected (Cutcliffe 2003). In my attempt to ensure that they felt emotionally and psychologically safe, I emphasised that the process was collaborative, that their anonymity was assured and that they could trust my promise and process of confidentiality.

Constructivism fitted the data analysis for this study, I was able to acknowledge that the meanings within the data were co-constructed between the participants and I. I knew I would not be searching for an objective truth, rather exploring the multiple realities that the participants and I share. This allowed for rich,

layered analysis where themes were not only categorised, but I deeply understood each participant's perspective. As a midwife, that meant I was able to interpret the data with sensitivity to the personal, professional, emotional and socio-cultural factors that influence maternity staff when implementing the BFI. The traditional notion of objectivity is challenged by constructivism, however within this framework, objectivity is reframed as having an awareness of my own influence on the research process, my reflexivity as a researcher.

5.3 Study design: Case study

For this research a qualitative approach was adopted, since the research aim is to explore the meaning that individuals or groups attach to either a human or social situation that may not be generally understood (Creswell and Creswell 2023), it also endeavours to investigate the subjective nature of knowledge. The participants of qualitative research are recognised as information sources, with their experiences and how these are expressed, being of value and integral to the findings and meanings that arise from the research (Creswell and Creswell 2023). A situation where qualitative inquiry would be suitable as a research strategy is where individuals have deeply rooted beliefs or values within their personal knowledge (Ritchie and Ormston 2014). The aim of this study was to explore the experiences of maternity staff which demonstrated why a qualitative methodology was chosen.

Case study research is a qualitative approach involving in-depth examination and analysis of a specific subject, for example a person, group, organisation, or phenomenon. Case studies are regularly used in clinical research (Creswell and Poth 2018) and enable the exploration of characteristics and meanings of the case. This research design allows for understanding different aspects of a research problem. Initially this study was a multiple case study to allow for comparisons between maternity units within the locality to be made, thereby highlighting the differing experiences of staff working with the BFI. COVID-19 restrictions did not allow for this. During the COVID-19 pandemic, many NHS staff were required to self-isolate away from the workplace if they were considered to be vulnerable and at high risk should they contract the virus. The pandemic therefore required NHS staff to work in new ways and new settings

with many being deployed to work in clinical areas that they were unfamiliar with to provide critical care. All staff were required to wear personal protective equipment (PPE) such as face shields and face masks and working patterns were redesigned with risk assessments being required for all staff (NHS England 2020). Social distancing of two metres was also mandated unless direct care was required. The deployment of staff and social distancing requirement were the factors which resulted in me being unable to attend the multiple case study sites as anticipated. This resulted in the one main study site becoming a single case to be explored in depth. Due to contractual and insurance purposes, as a university PhD student I was no longer able to attend the main study site to complete the research data collection. As has previously been discussed, this research was a clinical PhD studentship, an element of which was a requirement for me to work for the study site trust for seven hours per week in my role as a midwife. This is where I took opportunities to recruit and complete interviews, maintaining PPE and social distancing mandates.

A case-study design can be applied when there is a phenomenon to be studied in context, which is the rationale for the choice of this design here. The sample involved with the case study design is constructed around the context under exploration and the perspectives of multiple individuals as opposed to sampling individual participants (Ritchie et al. 2014).

With regards to case study research, the case study path typically commences following a thorough literature review which directs the posing of a well thought out research question. It is, however, accepted that the literature review process is an ongoing process throughout the study and not just an initial step. As mentioned, this PhD project had an initial literature review which was supplemented by smaller searches for literature related to relevant themes and issues identified as the study developed. On completion of the study and final writing if the thesis a final search of the literature was performed with the original search terms and strategy.

Case study evidence can be gleaned from various sources which complement and support each other. For the purpose of this study, direct observation of maternity staff during shift handovers was attempted, unfortunately due to

COVID-19 pandemic PPE requirements, the wearing of face masks inhibited the view of facial expressions therefore direct observation could no longer be included as a data collection method. Document analysis of UNICEF UK accreditation visits and document analysis of job descriptions of a range of maternity staff employed within the study site was completed to enhance the data analysis process.

5.4 Limitations to case study

One main criticism of case studies as a research design is a lack of generalisability of findings. By nature, case studies focus either on one single study site or a small number of sites as part of a multiple case design therefore raising the question of how generalisable the findings could be for the broad population. Whilst some single site case studies could be questioned regarding generalisability, although the BFI is unique to those services providing care to women, babies and families services, it is one which is a nationwide agenda supported by all governments of the UK. The uniqueness of my study topic does not impact how generalisable the findings are, all NHS trusts who are either BFI accredited or in the process of accreditation will benefit from the findings and recommendations of my study.

To avoid the question of researcher bias, I continued to revisit my position as an insider researcher, always aware of possible power imbalances and maintained my reflexive stance. The pragmatist ontology of the study allowed for the realities of the participants to be heard rather than my interpretation of their data.

A documented limitation of case study research is that a case study may be difficult to replicate. Maternity staff and the BFI are context-specific variables and maternity units are specific environments, however it would be fairly easy to replicate this study within a different study site with different maternity staff. Maternity staff nationally and globally will all have had personal and professional experiences of infant feeding.

As the sole researcher of this study, I developed all interview questions and personally interviewed all participants. COVID-19 restrictions required me to

consider how to access participants that was not in person, the decision was made to utilise online platforms to complete interviews. This resulted in easier access to many participants however the same amount of time was invested regardless of face to face or online interviews. What I did find as labour and time intensive was I personally transcribed, by hand, all interview transcripts. The PhD studentship allowed time for this to be completed, this may not be feasible in future study projects.

While case studies are valuable for exploring real-life complexity and providing deep contextual understanding, I am aware that they can be questioned as being limited in scope, generalisability and traditional scientific rigour. Although this study was labour intensive, it can be replicated elsewhere, and the findings are generalisable to all services who work with the BFI.

A qualitative case study methodology was selected to explore the BFI within its 'real-world' context. This aligns with the pragmatist ontology, which views reality as constructed through human actions and interactions, a practical epistemology was also adopted, emphasising experiential knowledge which is generated through active engagement with the BFI. Data collection involved direct observation of shift handovers, document analysis of UNICEF accreditation reports, and job description analysis.

The single case study approach enabled in depth exploration of the interplay between the factors that shape maternity staff experiences with BFI standards implementation at the study site. Pragmatism focuses the research on addressing societal concerns and generating practical solutions to barriers and problems. The reflexivity of the researcher is important, as interpretations actively construct study findings. This research provides insights into staff perspectives on BFI adoption, highlighting areas for improvement in implementation and practice. The chosen methodology adheres to standards for this qualitative PhD research.

Chapter 6 Methods

Chapter 6 provides details of the methods for data collection which were applied to this study and discusses the use of reflexive thematic analysis (RTA) for data analysis.

The methods section first outlines the study design as a qualitative case study using semi-structured interviews as the primary data collection method. Purposive sampling was used to recruit participants including maternity ward staff, midwifery managers, and neonatal unit nurses. In total, 17 participants were interviewed. Data collection took place during the COVID-19 pandemic therefore most interviews were conducted via online platforms.

Face-to-face interviews and documentary analysis were the qualitative research methods used for this study to gather in-depth and contextual information. Face-to-face interviews involved personal interaction between me and the participant which allowed for exploration of attitudes, experiences and opinions through open-ended questions. Initially these were in person, however due to COVID-19 pandemic restrictions I completed these using online platforms such as Zoom and Microsoft Teams.

I had initially planned to complete direct observation which entails systematically watching and recording behaviours and facial expressions of maternity staff within the maternity unit setting, this would have enabled capturing non-verbal cues that might not be captured through verbal accounts. The wearing of face masks as per COVID-19 restrictions meant that direct observation could no longer be utilised as a data collection method. In this instance I continued to gather data via informal conversations with my colleagues, they were all aware that any information discussed may be used within this research to which they consented.

Documentary analysis involves the systematic review of existing documents, in this case maternity staff job descriptions. They were analysed to extract relevant data, identify patterns and understand professional expectations. These methods of data collection can be used together to provide a deeper understanding of the experiences of maternity staff working with the UNICEF

UK BFI by capturing subjective experiences. Completing documentary analysis during the data collection stage enabled me to tailor questions to participants regarding job roles and responsibilities.

It was initially planned to use constructivist grounded theory for data analysis but I found RTA to be better suited upon engaging with the data as RTA acknowledges the active role of the researcher and their insider knowledge and experience. The six phases of RTA are described, though not as discrete linear steps. Coding was done manually with printed transcripts rather than using qualitative data analysis software. Themes were developed through visual mapping to identify connections and patterns across the data set.

Overall, the methods section provides an account of how RTA was applied inductively in this study. The insider position of the researcher as a midwife colleague is viewed as a strength to enable deeper interpretation and latent coding.

6.1 Peer review of interview guide

Peer review is an important process for academic work therefore prior to commencing any data collection, a midwife colleague took part in a semi-structured interview via Microsoft teams. This enabled the opportunity to put into practice the interview guide which had been developed for this study. This pilot interview assisted with the decision as to which questions would be most beneficial for the study purpose, which questions needed to be removed and where participants would need to be probed further (Van Teijlingen and Hundley 2001).

Peer feedback was that the questions on the interview guide were asked in a clear manner with a conversational feel to it which my colleague deemed to be positive. There was a feeling that there may have been an aspect of leading my peer into an answer, however it was felt that this was more prompting than leading. Having the ability to prompt was beneficial, as it assisted with guiding back onto topic when it appeared that my peer was losing her train of thought. Completing this ‘pilot’ interview via Microsoft teams highlighted that the online programme caused a slight time delay for the response so when interviewing

participants, I needed to be aware of the lag, to ensure sufficient time for them to answer questions and that I did not interrupt when they were about to reply. Following the interview and acting upon my colleague's feedback, one question was removed from the interview schedule as it was deemed to be very similar to another question within the interview guide (Appendix 2). During data analysis it was discovered that asking the participants about loss of accreditation was absent from the interview guide which may have limited the study in this area and would be a consideration for future research.

6.2 Participants and recruitment

6.2.1 Identifying the sample

Purposive sampling is a process where participants are selected as they possess the characteristics required by the researcher to explore the phenomenon being studied.

The range of maternity staff who were recruited and interviewed included band two maternity support workers, band three senior postnatal maternity support workers who are also known as 'the infant feeding team', band five midwives, band six midwives and band seven midwives. An infant feeding lead staff member and band eight midwifery managers were purposively recruited.

All of the participants provide maternity care and work in a range of areas within the maternity unit and work a variety of shift patterns. Some staff are employed to work as part of an integrated midwifery model where they provide antenatal, intrapartum and postnatal care within the maternity unit as well as providing community antenatal and postnatal care. Some are purely based in the maternity unit providing postnatal care or work a constant pattern of night shifts covering both the labour ward and postnatal ward, other staff work as part of a well-established homebirth team.

Maternity staff ranging from band two to band seven were classified as the main sample.

The main sample participants were chosen for their theoretical purpose and relevance, these maternity staff members have direct contact with women and experience of the BFI. With data collection progressing and the beginning of

thematic analysis, themes were being identified which highlighted where there were gaps in the collected data. This informed which participant group should be approached next for data collection (Glaser and Strauss 1967, Gillham 2005) When the gathering of data is based on the analysis of previous data (Corbin and Strauss 2015), the process is known as theoretical sampling.

Creswell and Creswell (2017) state that although there is no definitive answer to the question of what an adequate sample size is in a qualitative study like this one, they offer the idea that for a research study with a qualitative approach, a sample of five to twenty-five is a starting point. This study consisted of a theoretical sample of 13 maternity ward staff who have experience of working with the BFI. The participants ranged from student midwives, band two and band three maternity support workers and qualified midwives.

Three band eight midwifery managers were purposively selected. Purposive sampling is a process where participants are selected as they possess the characteristics required by the researcher to explore the phenomenon being studied. This method of sampling was utilised for the midwifery managers as it was presumed that they had received a level of education and practical training of the BFI.

As the process of purposive sampling is to select participants who possess characteristics required by the researcher (Ritchie et al. 2013), midwifery managers and a senior neonatal unit staff members were invited to participate; they were identified as being pivotal within their job role regarding BFI implementation and change management. An infant feeding lead staff member at the study site was invited to participate as she had previously had responsibility for training maternity staff in the BFI standards. These four senior staff members were each sent an encrypted email inviting them to participate, all of which replied and consented promptly.

The total sample was 17 participants. No new data was gleaned from participants number 16 and 17 therefore the decision was made to stop data collection.

6.2.2 Participant inclusion and exclusion criteria

This study focussed on a service provision within maternity services therefore maternity staff were the targeted population. The inclusion criteria were local maternity ward staff with training in and experience of working with the BFI, neonatal unit staff, midwifery managers and student midwives on placement at the hospital. Staff in specialised infant feeding roles at the study site and in neighbouring maternity hospitals within different NHS trusts were invited to participate. Exclusion criteria included: local maternity staff without BFI experience, this was a challenge in itself due to a number of maternity staff employed in the study site that had not attended any BFI training due to its absence within mandatory staff training; medical staff, community midwives, nurses and health visitors, student nurses and all non-English speaking staff. The staff groups within the exclusion criteria do not possess the knowledge and experience of working with BFI which was required for this study. Staff were asked at initial point of contact regarding their ability to read and understand both the information sheet and agreement form which were written in plain English with no jargon.

Table 2 Participant inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
Maternity unit staff, midwives, maternity support workers, neonatal nurses	Community nurses and health visitors, domestic staff, medical staff
BFI experience and training	No BFI knowledge/experience/training
Neonatal unit nurses and midwives	Nurses and midwives not working in neonatal unit or maternity unit
Student midwives on placement at study site/hospital	Student midwives on placement in different hospital trusts, Student nurses, medical students
Midwifery managers	Other managers in the NHS Trust
English speaking	Non- English-speaking

6.2.3 Study recruitment

To meet the multiple case study design requirements, infant feeding lead midwives working in BFI projects within neighbouring maternity units were invited to participate in this study via email. These infant feeding leads were identified via their NHS Trust website and through PhD supervisor knowledge. Contact was also made through the NHS Trust research and development departments. These maternity units were selected as they would enable comparison and contrast to the study hospital owing to their size, remit and BFI accreditation status. The invitations were not accepted and then subsequently, due to the COVID-19 pandemic restrictions, it was not possible to include them in this study.

The study recruitment period was October 2020 – October 2021. The study was advertised at the participating hospital with posters and participant information sheets (Appendix 3 and 4) placed in key areas around the maternity unit setting. These key areas included staff rest areas, changing rooms, notice boards and on the backs of doors to private areas such as bathrooms and toilet facilities. Word of mouth aided with recruitment as many of maternity staff members were aware of the upcoming study due to general discussion with the researcher when she was working clinically. The study was also advertised in the Trust maternity ward monthly newsletter which is emailed to all maternity staff groups. An encrypted group email was sent by the researcher to all staff explaining the purpose and aim of the study with a link to the participant information sheet. This email originated from a designated research email address set up within the secure NHS email system. Potential participants who were interested in the study were informed to make official contact with the researcher through email, phone call or text message. This contact enabled a discussion of the proposed methods for data collection and to sign a paper consent form, a copy was offered to each participant and a copy was kept by the researcher for official research records.

These recruitment methods resulted in the successful recruitment of the main study sample, including those who were purposively selected. No extension of the recruitment period was required.

A closed Facebook group was developed to invite local maternity staff members from an already established maternity group to join the study page. The page description included the details of the study such as the title, the proposed methods, including sample inclusion and exclusion criteria and data collection methods. This resource for recruitment was not utilised due to the success of the other methods previously stated.

6.3 Ethical considerations

6.3.1 Applications for ethical approval

Prior to advertising the study officially and beginning data collection, ethical approval was necessary from the Faculty of Health and Social Sciences at Bournemouth University, the NHS Health Research Authority (HRA) and the Research and Innovation department at the local NHS maternity hospital.

The process of applying for ethical approval at BU required the completion of an online ethics checklist, the summary of my study protocol and copies of the participant information (PI) sheets, consent forms and interview guides. This checklist was sent to the Research Ethics Committee (REC) who granted approval.

Following receipt of ethical approval from BU REC, an application was made to NHS HRA via the Integrated research application system (IRAS). This process was necessary as I was interviewing maternity staff employed by the NHS, the outcome of the application was to proceed with no recommendations or restrictions provided to the researcher.

6.3.2 Consent, confidentiality and anonymity

The principial of informed consent is well documented and it is acknowledged that research participants have the right to consent and refuse to participate. There is a requirement therefore to ensure they are provided with comprehensive information (Franklin et al. 2012). I gained signed consent from the participants once they had received verbal information, had read the PI sheet and (Appendix

3) and following the opportunity to ask questions about the study. I then conducted the interviews within a week of participants signing the consent form (Appendix 1). This was based on the availability of the participant and researcher. Participants were informed that they could withdraw their consent from taking part in the study at any point; they were aware that should they withdraw at the time of data analysis, any data from them will have already been anonymised and therefore non-identifiable and as such could not be removed from the findings. Once transcription was complete, a pseudonym which was chosen at random by the researcher was allocated to anonymise the data. Participants were assured that the study data would not jeopardise their anonymity. Names and any identifiable information were removed from the findings and discussion within the thesis to ensure anonymity.

Confidentiality was maintained at all times. Study data, including PI sheets signed consent forms and paper transcripts were stored in a secure, locked filing cabinet within the maternity department; I was the only person with a key and access to the cabinet. Computer data was encrypted and stored on a secure laptop with password code access that only I had access to. Participants were informed that there would be occasions where I would need to share the recordings and/or findings with my study supervisors; this occurred during the data analysis stage and coding process to ensure reliability. All participants consented to discussion with supervisors where necessary.

6.4 Document analysis

Job descriptions were accessed for band two and band three support workers and band five, six and seven midwives. The strengths to performing document analysis is that the information within these documents is unbiased and objective. They were specific regarding job titles and role expectations which assisted with data analysis and corroboration (Yin 2014), where participants were uncertain regarding the job roles of their peers of different band levels. A further strength to utilising documentation as a source of evidence is that they provide information which covered a time span of many years highlighting changes within job roles.

6.5 Direct observation

Direct observation of maternity staff during a range of shift handovers was to be commenced. The purpose of this form of observation was to gain insight from the behaviours of staff regarding discussion of infant feeding support and care between various members of staff, their body language and facial expressions were of interest. Unfortunately, when data collection began it was during the COVID-19 pandemic, subsequently all maternity staff were required to wear face coverings which made observation of facial expressions impossible and so the decision was made to no longer continue attempting with this source of evidence collection.

6.6 Semi-structured interviews

The data collection instrument used within this research was semi-structured interviews, guided by open ended questions. With this research being qualitative in nature and due to the inherent nature of interviews being flexible (Gillham 2005), it enabled the participant to determine their own answers allowing for an interactive and responsive relationship between the researcher and the participant (Gillham 2005). Structured interviews lend themselves to a rigid series of questions to which participants respond with closed ended answers. To gain a more rich and less superficial dataset, semi-structured interviews were viewed as the better suited method for data collection. This was important for the study as it would allow for further exploring of the reply which would be individual to the participant.

A purposive sample of relevant staff including three midwifery managers, one neonatal unit manager and the infant feeding lead staff member were interviewed following a semi-structured interview approach. The interview guides (Appendix 2) were developed using open ended questions which ensured that all participants were asked the same basic set of relevant questions but also allowed a free-flowing process to take place so that any topic could be discussed with answers to questions being determined by the participant (Gillham 2005, Creswell and Creswell 2023). This allowed for real time responses to the experiences or situations as discussed by the participant.

Face-to-face interviews which were digitally recorded were the favoured approach when planning and commencing data collection. I was dubious of utilising online platforms as it was felt that non-verbal cues may be missed (de Villiers et al. 2022)or that internet connections could be poor thereby affecting the quality of the recording. As a midwife researcher and key worker, I was in the fortunate position of having access to colleagues who were potential participants. My colleagues and I were present within the clinical area which enabled the opportunity for face-to-face interviews more readily.

However, as the data collection occurred throughout the COVID-19 pandemic there were some obstacles to overcome. The clinical workload was extremely busy, which meant that on some occasions, even when signed consent had been obtained, there was not available time to complete the interview. Due to the difficulties that I was encountering with face-to-face interviews, online platforms such as Zoom and Microsoft Teams were then considered necessary. They became the most accessible methods in which I could interview participants (de Villiers et al. 2022). The online interviews took place at a time most convenient for both the participant and me. Each participant appeared very comfortable in their home surroundings, there were minimal internet problems encountered, they were recorded with consent to allow for transcription and all participants gave positive feedback regarding the method.

The second national COVID-19 lockdown was announced in October 2020 which was when data collection was planned to commence. Five interviews were completed prior to this lockdown announcements but subsequently data collection was paused for a period of six months. Data collection was recommenced and completed following the end of the third national lockdown in March 2021, see figure five.

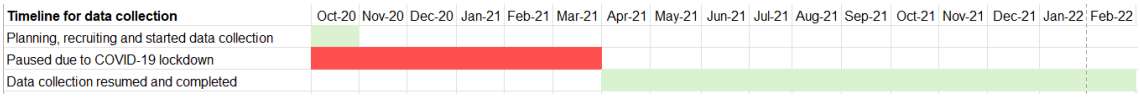

Figure 5 Timeline for data collection

In places throughout the interviews, it became conversational which is something I became aware of and acted upon to ensure that it did not cause me to use

leading questions. I was concerned that by deviating from the semi-structured interview guide, it would impact on the reliability of the study, however Mockovak (2016) writes that advocates for a conversational style of interviewing suggest that it can relieve any burden from the participant enabling the potential for higher quality data being provided (Mockovak 2016). Although the purpose of the interviews was for research, they involved humans interacting with each other, I had to become reflexive in my approach and be aware of any bias or preconceptions of the topic being researched (Gillham 2005). There were two occasions when the participants used swear words. At the time this made me feel slightly uncomfortable as I was unsure of how I would transcribe these or how they would be published. I realised that this language would not be routinely heard within a professional environment. This made me realise that I needed to carefully analyse what the participant and I were discussing in the preceding conversation, as it may have demonstrated strong emotions such as passion or frustration.

The online interviews appeared to be very successful and became the choice of data collection method moving forward. My concerns about non-verbal cues and body language and the effect a video may have on detecting subtleties were somewhat alleviated but I was still concerned about internet connections and loss of the recorded video. As I transcribed immediately after each interview, losing the data which had been recorded was minimised. They provided much easier access to participants with little disruption to both of us. Perhaps being comfortable in the home environment allowed participants to speak much more freely than if we were in the clinical setting.

Immediately after each interview, I transcribed the data, saving it into a pdf document to allow for coding. Transcribing is something that I made the decision to do myself early in the data collection process as I felt closer to the data and could be back in the interview remembering connotations and how words were said by my participant which assisted with analysis, this would have been lost to me if I had external assistance with transcription (Bailey 2008).

Nearly always, the conversations developed easily within my interviews. I was very aware of my role as midwife researcher and reflexivity was in the forefront

of my mind. Participants said frequently “you know” and while I did know what they meant or were implying, I ensured that I asked them to elaborate. This ensured that they were explicit in their meaning and that I was not misinterpreting what they were saying or trying to say. Some participants had mentioned confidentiality whilst talking, that gave me the impression that due to my midwife role they were concerned that I may tell others what they had said, I reassured them on all aspects of confidentiality and anonymity (Saunders et al. 2015)

6.7 Data analysis - Reflexive thematic analysis (RTA)

Reflexive thematic analysis as demonstrated by Braun and Clarke was applied to the study data which was collected from each individual participant. During the analysis process, this data was reconstructed so that their stories could be retold as a collective of all the participants (Miller 2015)

Initially, the constructivist grounded theory (GT) approach, as described by Charmaz (2006) was to be applied to the study data, however when commencing data analysis, it became apparent that approach was not fit for purpose. It felt uncomfortable to me that I was required to separate my own thoughts and experiences from the process, that I needed to be an objective outsider. As I familiarised myself with the transcripts, commenced coding and analysing the data, I became aware of the work by Braun and Clarke (2006 2013 2017 2019 2021 2022) on reflexive thematic analysis (RTA). Since 2006 when Braun and Clarke wrote their paper “Using thematic analysis in psychology”, they have published many more papers and book chapters explaining the evolution of RTA, the main premise of which is to acknowledge the active role of the researcher in the research process; reiterating that this approach was better suited for this study than GT. I did not simply want to give voice to what my participants were saying, I did not want to interpret what they were saying or how they felt and lived their experiences. I wanted their voices to be heard so that their experiences of working with the BFI remained true. The RTA approach also considers what attributes I bring to the research as a registered midwife and an NHS BFI lead midwife. These attributes are seen as adding an advantage to the research in that my experiences will bring value to the interpretation of the dataset.

There are three broad types of TA (Braun and Clarke 2022). One uses a coding reliability approach which centres around a framework for coding, a second revolves around a code book where themes are developed early in the research process and is used to document or chart any ongoing and developing data analysis. The third type is RTA which involves the development of themes occurring later during the coding process, these themes arise from patterns of shared meaning across the data set rather than individual items of data (Braun and Clarke 2022) . The basis of RTA involves six recursive phases. These phases or 'steps' are well documented, but Braun and Clarke (2022) are very clear that their intention was to never provide a protocol, guidance or a step-by-step tool for researchers to use. Their view is that they provide a "starting point for a journey, not a map" (Braun and Clarke 2021). My interpretation is that the phases are to be applied in a more fluid approach or recursive interlinking of each step, which I found was occurring when analysing my dataset (Braun and Clarke 2021).

Reflexive TA focuses on identifying themes across the whole data set rather than individual data items (Braun and Clarke 2022). There is no definition of an optimal sample size for data collection, what is important and is the main purpose of RTA is to identify and construct, actionable outcomes that have implications for practice (Braun and Clarke 2022). That definition fits perfectly within this research; the expected outcomes are to identify what the facilitators, barriers and challenges are, for the implementation of the BFI within a maternity service. The findings and recommendations will have an impact on how the practice of maternity staff will change to benefit themselves, as well as the women and their families that they care for. I wanted to know how maternity staff feel when working with the BFI as a framework, what their experiences were when working with it and how much experience they have of applying it to practice. I did not want to generate a grounded theory; my aim was to identify the patterns in their words. Grounded theory approaches suggest that themes within the data emerge, that it simply needs to be found by the researcher (Glaser 1978), whereas with RTA, data needs to be interpreted prior to theme development (Braun and Clarke 2022). The RTA interpretation of data will

assist in identifying what is at the crux of the experiences of the maternity staff within this study (Braun and Clarke 2022).

Braun and Clarke (2017) write that:

> "thematic analysis is a method which is not bound by theoretical commitments as other research methodologies are".

TA is not a research methodology yet that does not mean that it is atheoretical, it can be applied across a range of theoretical frameworks and research paradigms, the very nature of being reflexive and interpretive provides the rigour and validity to RTA being a theory-based research method (Braun and Clarke 2022).

As has been discussed in Chapter two, to demonstrate qualitative sensibility in research, the researcher needs to demonstrate reflexivity, whether that be as an insider or outsider position. I could not be an outsider; I have knowledge and experience and was in a privileged insider position. As a qualified midwife I already had excellent interactional skills with my participants who were colleagues. We all knew each other; we had trusting relationships. Some bonds that I had with participants were stronger than others, however, I did not feel at any time there was ever any discomfort between us, all participants were happy to speak with me. Being aware of reflexivity as a researcher is essential for good qualitative research, it aids critical reflection of the knowledge that is produced and my active role in producing that new knowledge. I could not claim that my midwifery experience would not influence me as an insider researcher throughout the whole research process, but I did my best to remain neutral when required.

Braun and Clarke (2022) do not wish for their 'six steps' to reflexive thematic analysis to become a prescriptive protocol to follow. However, although I did not take a step-by-step process, for ease of understanding, I will discuss my data analysis process, under the headings of the six phases, in six sections below.

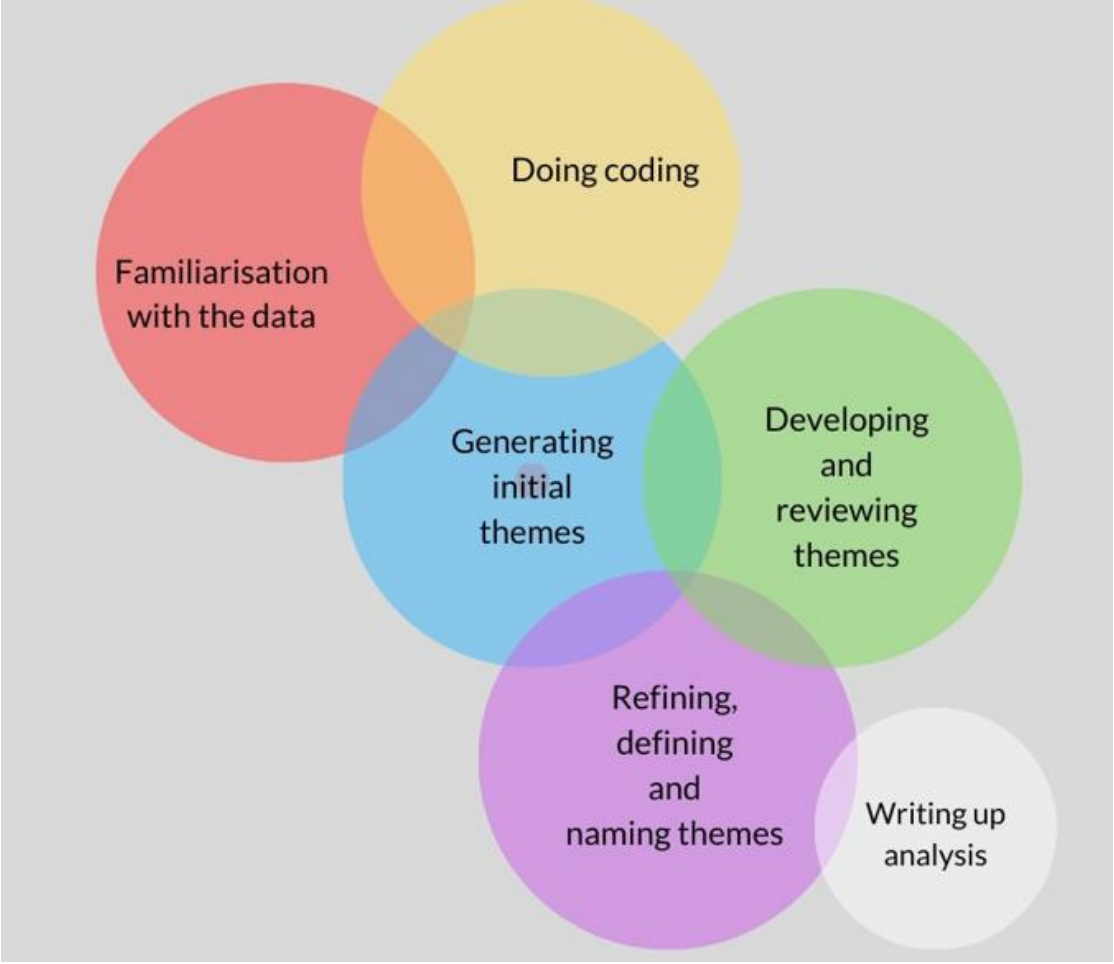

Figure 6 Reflexive thematic analysis: six phases of analysis (Braun and Clarke 2022)

Phase one: Familiarisation with the data.

I was the sole researcher for this study, I interviewed all 17 participants face to face. The first six interviews took place within the maternity unit, observing COVID-19 social distancing guidance, they were face to face with the use of a voice recorder and note taking. The remaining 11 interviews were completed using online platforms such as Zoom and Microsoft Teams. These were recorded with inbuilt transcription as part of the recording. Once an interview had taken place, I transcribed it the same day to ensure it was completed prior to the next interview. When using the voice recorder and headphones, initially, I handwrote the transcripts onto paper. I did this for the first three interviews and then typed them up and produced a Microsoft Word document. The following two interviews, which were also recorded with the voice recorder, were transcribed directly into a word document with the aid of the recorder's

transcription software. This increased my workload and became extremely time consuming due to the very poor transcription provided. The interviews that were completed with Zoom and Microsoft Teams, were also transcribed by the software for the programme, this transcription was also inaccurate at times. All 17 interviews were listened to whilst I edited the initial software transcriptions. After the initial interview, I listened to each interview a further two times to complete the process of transcription. I then read each typed transcript a final time whilst listening to the recorded interview. This allowed me to become very familiar with my data, enabling me to remember non-verbal communication, inflections, eye rolls and movements and changes to tone of voice. By re-reading the transcripts in this way ensured that I was and still am very familiar with my data. It was at this point I began the coding process.

Phase two: Doing coding.

With RTA, the codes applied to the data, generate the theory output (Braun and Clarke 2022). The process of coding is to identify where the shared patterns of meaning are within the dataset (Braun and Clarke 2022). Where these meanings sit within the data was not determined prior to data collection, as the decision for RTA was not made until the coding process began.

A computer software package for qualitative research data analysis, NVivo 12, was accessed at the beginning of the analysis process. After importing the first six transcripts, coding began. Initially the coding process commenced with line to line coding, this followed grounded theory coding processes, which at the time was felt to be the approach to be used (Glaser 1978), but it just did not make sense to me. In response, portions of data, as opposed to line to line, were then read and coded with words or short phrases. However, doing this within NVivo 12 resulted in multiple single word codes across the data set which felt difficult to manage, resulting in a feeling of being detached from the data, I felt that the software became a barrier. It was at this point a decision was made to convert every transcript into a hard, printed copy. Each transcript was anonymised, they were printed and filed in a folder in numerical order of when the interviews took place. The coding process was then restarted, from the beginning, no longer using NVivo 12. Highlighter pens were used to make a

reference list, each pen colour was attached to a code. The colour for the corresponding code was applied through all the transcripts which assisted with identifying the shared meanings across the dataset. Having a hard copy also enabled note writing next to and about the data which asked questions of meanings within the data and highlighted similarities to other transcripts. Being so familiar with the data ensured a knowledge of what all participants had said and where links could be made, which also assisted with identifying where there were shared meanings. Making notes within the transcripts and realising comparisons resulted in more familiarity with the data, links were made and similarities noted. All the transcripts were interlinked in some way.

Figure 5 demonstrates that the familiarisation with the data and the coding overlapped with each other (Braun and Clarke 2022) which was found in this study where they informed each other. Coding could not have begun without being familiar with the data, yet the process of coding resulted in becoming more familiar with the data and as these two phases were in progress, initial themes were generated. Familiarisation with the data also overlapped with generating initial themes, not only during coding. Becoming familiar with the dataset also allowed themes to develop. It was not a step-by-step process, the first three phases of RTA were recursive, like cogs turning together.

From repeated engagement with the data, analysis became deeper (Clarke and Braun 2017, Braun and Clarke 2022). The process of becoming familiar with the data and coding, revisiting the transcripts and connecting them allowed me to get a deeper understanding of the data that was in front of me. The systematic process of reading each transcript alongside watching the recordings, returning to them and linking with other transcripts demonstrates engagement with the data, ensuring that patterning across the whole data set was identified and that the process of theme development was robust, which demonstrates rigour when applying analysis to my data. I did not have any definitive preconceived ideas of all the potential themes within the data, however, I have knowledge and experience of working within a BFI accredited unit and therefore had an idea where there could be barriers within the study site. I ensured that this did not impact data collection and that patterns identified

within and across the data were not fitted into any preconceived barriers/frameworks that I may have identified prior to the commencement of this study. There were codes that evolved through data analysis that were expected as well as unexpected codes. As this happened, my understanding of the data set developed. The more I re-read them the more they developed. Through this developing and re-reading it allowed for the identification of shared and similar meanings, rather than a lengthy list of seemingly unrelated codes that were within Nvivo 12. There were codes that occurred once within some transcripts but were very relevant, subsequently they were added to a theme.

Coding within RTA is subjective (Braun and Clarke 2022). Having one researcher who completes coding ensures that familiarisation with the data occurs, there was no requirement of another person to agree codes, the skills I possess in my position as a midwife have influenced the coding process. This subjectivity is viewed as a strength by Braun and Clarke (2022). The process was shaped by my interpretation of the data set alongside the data being shaped by what I wanted to gain from it. Different coders will make sense of data in different ways, so for RTA it is good practice to have only one person coding (Braun and Clarke 2022). The main orientation that I took was an inductive approach, where codes and themes were derived from the data. I was expecting some codes to emerge which would lend themselves to deductive coding, yet there were purely inductive codes which were present and unexpected.

Deductive coding in RTA refers to the process of coding which is steered by the researcher as opposed to the data, meaning that stories and experiences within the data set reflect ideas that I wanted to know in response to the questions that I asked (Braun and Clarke 2022). This can be seen where midwifery managers were asked specific questions (Appendix 2). With familiarisation with the data, and at least two participants saying the same thing, about one particular topic, a theme was developed. The emerging theme and the connection to published literature was evident at the beginning of the coding process, therefore I continued to code deductively around that concept.

Braun and Clarke (2022) discuss that there are two types of codes; semantic and latent codes. Semantic codes are codes which capture explicitly stated ideas which are relevant to the research question being asked (Braun and Clarke 2022). During analysis, these are the codes that were developed that stayed close to the language of the participants, during coding some of those codes remained semantic. As data analysis developed some codes became latent level, meaning that conceptually they had a deeper meaning than their surface suggests (Braun and Clarke 2022). My position as a midwife and colleague assisted with latent coding as I was aware of occasions where there was unspoken meaning behind participants answers. Being present at all the interviews and subsequent familiarity with the data meant that I witnessed body language and facial expressions, which was especially useful for those times where only a voice recorder was used during the interviews. Recalling a knowing smile or an answer followed by "you know", gave me the ability to code with more meaning applied to it than if multiple coders were involved. I knew there was implicit meaning to the answer which highlights the latent codes which refers to the hidden, not obvious or concealed meaning to words of the participants; capturing unconscious meanings of what is not being said.

Phase three: Generating initial themes.

The generation of initial themes occurred as a recursive process when becoming familiar with the data, coding and incorporating the notes made throughout the coding process (Braun and Clarke 2022). I continued to work on paper, using mind maps to assist with theme development. I began to group codes together that had shared meaning and were connected, this allowed for the generation of themes. Many codes were linked with more than one theme and were included in each relevant theme. This process of visual mapping allowed for the exploration of how codes related to multiple themes and how themes related to each other. The findings from this research are extremely interlinked, this mapping process was key for analysing the dataset and identifying the connections, interconnections and where there were disconnections. In this phase themes were tentatively generated.

Phase four: Developing and reviewing themes.

Phase four involved reviewing the initial themes by revisiting each mind map to ensure that each theme included all the relevant data. During this stage, the whole dataset was revisited, both in NVivo 12 and all paper transcripts were re-read. This process enables a deeper analysis and highlights codes that may not have been noticed previously or were not initially thought to have relevance (Braun and Clarke 2022). Once this process had been completed, a final check was performed to confirm that all codes had been transferred and were present in their related theme. As discussed, the codes were interlinked with more than one theme in many cases however the initial themes that were generated did not change following review.

Phase five: Refining, defining and naming themes

Figure 6 below shows the named themes.

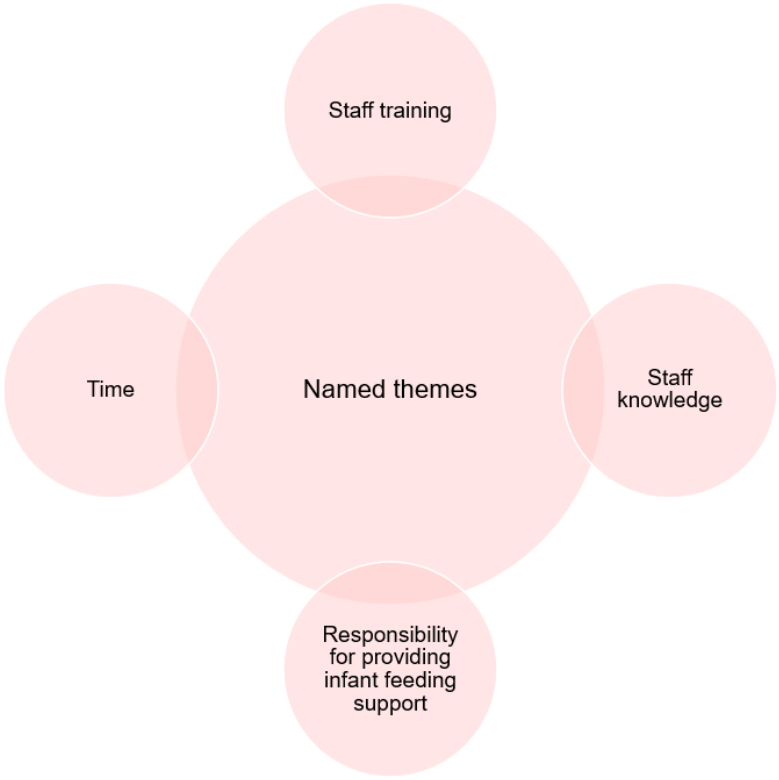

Figure 7 Named themes identified through reflexive thematic analysis

Throughout the thematic analysis process, it became evident that if there was a lack of belief and support from managers, no time would be allocated for staff training. A lack of staff training would result in a lack of staff knowledge. If staff had low knowledge levels they would refer to colleagues who may question

whose job it is to complete the request. Time would also be required to complete the job.

Phase six: Writing up analysis

This phase was completed within the findings section of this thesis.

This methods section demonstrated the application of RTA for this study which explored maternity staff experiences with implementing the BFI. Semi-structured interviews were conducted with 17 participants. The researcher, a midwife herself, took an insider approach to data analysis using RTA. This allowed pre-existing knowledge and collegial relationships to aid deeper interpretation of data through manual inductive coding of printed transcripts. Visual mapping identified connections between codes leading to theme development. The fluid, recursive nature of RTA phases is emphasised rather than following a rigidly prescriptive ‘step’ process. Overall, the document provided an example of applying RTA in a way that embraces the researcher's insider status and professional experience as an asset to this qualitative research.

Chapter 7 Findings from document analysis

7.1 Document analysis

I have analysed job descriptions within the study site for a range of staff who are employed as band two, band three, band five, band six, band seven, band eight and a band seven BFI lead midwife role as part of this research to gain an understanding of the key skills, qualification and infant feeding responsibilities that are required for these specific roles within this maternity service. This analysis aided in identifying expectations and gaps between the job descriptions and expectations of staff when providing infant feeding support. Analysing these documents will assist with ensuring that recommendations are informed, supporting the development of the workforce and ultimately supporting the successful implementation of the BFI within this maternity unit.

The documents are job descriptions which are used to recruit into the roles. They are developed by a range of staff within the maternity unit for those they have responsibility for, for example, the current band two job description was developed by a band seven midwife who had managerial responsibility at that time for the cohort of band two support workers. All job descriptions were clear with the key role requirements and person specifications documented in bullet point format. The date ranges for all the documents were 2020-2022 however it is unclear as to why they have been updated as there are little changes present.

Deductive coding was applied to the dataset to determine what are the infant feeding care and support expectations and requirements for staff of all bandings. The themes that were being coded for were ‘infant feeding’, ‘UNICEF UK BFI’ and ‘breastfeeding’. These are presented within table three.

This analysis highlights that there is not a clear focus of the BFI for all staff bands with no mention of infant feeding support for the band seven staff group. The implication of this pattern could explain why the band five and six midwives refer to the band two and band three maternity support workers, but there appears to be a lack of responsibility for the band seven team to apply the UNICEF UK BFI to their practice.

Table 3 Themes from job description analysis

Role banding	**Theme: Infant feeding**	**Theme: UNICEF UK BFI**	**Theme: Breastfeeding**
Band two: Maternity Support Worker	Care and advice about infant feeding Key result area – physical skills to assist women with basic infant feeding advice for both breastfeeding and bottle-feeding families	Person specification states that they need to have a basic understanding of UNICEF UK BFI and infant feeding principles	
Band three: Postnatal Maternity Support Worker	Must have experience of providing infant feeding support Formulate care plans to support infant feeding	Actively contribute to maintaining the UNICEF UK BFI accreditation	Run breastfeeding groups Support breastfeeding in the community setting

	Be confident to provide detailed infant feeding advice		
Band five midwife	Plan, deliver and evaluate evidence based infant feeding support for babies in a range of settings		
Band six midwife	Plan, deliver and evaluate evidence based infant feeding support for babies in a range of settings		Person specification is a requirement to have at least two years' experience of providing breastfeeding support
Band seven midwife	No data	No data	No data
Band eight midwife		Manage and promote UNICEF UK BFI Maintain UNICEF BFI award	Lead on the promotion, training and support of breastfeeding
BFI lead midwife (Band seven)	Develop guidelines and policies on infant feeding	Lead on the strategic planning, implementation	Maintain the BFI to ensure local

		and maintenance of the UNICEF UK BFI standards across the NHS trust Progress the BFI accreditation project to full achievement	breastfeeding initiation and continuation rates improve

7.2 Introduction to maternity staff job descriptions

Chapter seven presents findings from document analysis of job descriptions for various bands of maternity staff at the study site hospital. The aim is to outline the roles and responsibilities related to infant feeding support expected at each staffing level. Within the NHS, there are a variety of staff groups with job descriptions and person specifications which identify the expectations of their role. Their remuneration is determined by their skill set. An explanation of each of the pay band classification and role description/expectation is provided.

The analysis covers bands two through to band eight. Lower bands have more task-oriented duties while higher bands have greater clinical and managerial responsibilities. A key finding that is explicit is infant feeding responsibilities increase with each band level. Band two support workers are expected to provide basic breastfeeding support under supervision. Band three support workers provide more detailed feeding advice and maintain BFI standards. All midwives are clinically responsible for maternal and infant care, with higher bands expected to have greater infant feeding experience. Band eight midwives and the BFI lead midwife role have strategic BFI leadership roles.

7.3 Band two maternity support workers

A band two is the lowest NHS entry salary on the scale. Band two support workers are supervised by a registered midwife and often assist with caring for mothers and babies both during birth and in the postnatal period. On the study site, band two support workers work shifts providing 24-hour cover and work in all clinical areas.

Dated January 2022, the job title for a band two within this maternity unit is ‘Maternity Support Worker’. The job description for the band two support workers at this trust states that their job purpose is to carry out a wide range of tasks which support the maternity service including personal care for women and advice about baby care and infant feeding, alongside a considerable amount of cleaning rooms, changing beds and handing out meals. It is expected that they work under the direction and supervision of the registered midwives in the service but also prioritising their workload using their own initiative. Infant feeding is documented

both in key result areas and person specification outline. The key result areas states that the physical skills required will be to assist women with “basic advice” about feeding their babies – both breastfeeding and bottle feeding and washing and bathing babies and teaching parents how to do so. The responsibilities, which they are expected to provide for the parents are for demonstrations of safe preparation of bottle feeds, assisting mothers to breastfeed and to use a breast pump, this may include cup and syringe feeding. Within the person specification it states that there is a need for some “basic knowledge of UNICEF BFI and infant feeding principles”. Other roles that they are to perform include undertaking certain clinical tasks such as the removal of urinary catheters and intravenous cannulas. They have general administrative duties and an expectation to work with student nursery nurses and to teach them patient and baby care skills. They are also required to clean rooms, move beds and furniture, empty bins and restock the ward area.

Within the organisation chart they are placed at the bottom alongside the administrative staff, the next staff group above them is the band three support workers.

7.4 Band three senior maternity support workers

Band three support workers are the next level up within the organisation, they undertake a range of delegated clinical duties in addition to the tasks which a band two undertakes. In this maternity unit there are band three staff that either focus on antenatal care or postnatal care and work either hospital based, community based or an integration of both. A requirement to be successfully employed into this role is a passion for infant feeding, particularly breastfeeding. All of the band threes currently employed here work a range of early shifts (07:30-14:30hrs), late shifts (13:30-20:30hrs) and long shifts (07:30-20:30hrs) seven days a week. There are a few within the team who work occasional twilight shifts which can be 18:00hrs until 22:00hrs or 00:00hrs, dependent on their own circumstances, especially childcare. They are not currently expected to work for a complete night shift (20:00-08:00hrs) as there just simply are not enough of them to provide 24-hour cover. This shift pattern is almost identical for both bands of support workers, the exception being the twilight shifts. Band two support

workers must work for the complete night shift, they do not have the option to work twilight shifts as a routine working pattern.

I have been provided with two separate job descriptions and person specifications. The first one to be discussed here is the current and up to date version which is dated July 2020 and is currently in use for advertising positions. The job title is 'Postnatal Maternity Support Worker'. The primary job purpose for a band three is to support the midwives in the provision of postnatal care in the hospital and community setting, occasionally in the absence of a midwife. They are required to formulate care plans to support infant feeding in discussion with a midwife although there is a considerable amount of independent working closely with a midwife. Their key result areas regarding the responsibility to women and babies include providing many aspects of postnatal care such as the removal of intravenous cannulas, removal of urinary catheters, performing vital sign observations on mothers and babies, obtaining blood samples and weighing babies alongside providing detailed infant feeding advice. "Advice" is the term used throughout the job description, it could be suggested that "support" or "information" are preferable terms. The specific infant feeding responsibilities are to contribute to the provision of antenatal education groups for families and to run breastfeeding groups, when working in the community area they are present to particularly support successful breastfeeding. A band three must be confident to provide detailed advice around all aspects of infant feeding and to identify those mothers who are struggling with the transition to motherhood. They are also expected to actively contribute to maintaining UNICEF BFI accreditation. Within the person specification for a band three support worker there is a requirement for experience of providing infant feeding support. Regarding qualifications, they either need to have completed, or be willing to complete an NVQ level three course. The opinion of a band three support worker is that there is no 'official' requirement for the band three team to complete an NVQ even though midwifery managers had stated that the ideal would be for all band three staff to have gained a level three qualification. The NHS Trust pays for both the course and the study time for staff with the expectation of completion in two years. Once completed band three staff do not get paid a higher salary.

The second job description is dated from 2017, the job title ‘Senior Maternity Support Worker for Postnatal Care’. Here the document states that the purpose of a band three is ‘to support the midwives in the provision of selective postnatal care both on the postnatal ward and in the woman’s home, contributing to the plan of care and working independently, having consultations with midwives when required’. They are positioned at the bottom of the hospital organisational chart alongside band two support workers, all bandings of midwives (as explained below) and the administrative team. The responsibilities for the families are the same as the 2020 job description previously mentioned, however the current job description has the addition of the expectation to contribute to the provision of antenatal education. There is a requirement that they will work with student nursery nurses and ‘teach them patient and baby care skills’. Similar to the band two support worker team, roles that are required of the band three support workers which are not solely related to infant feeding or postnatal care are to clean rooms, move beds and furniture, empty bins and restock the ward area.

7.5 Band five midwives

The job description and expectations for a band five midwife at this NHS trust was updated in 2020. Their job purpose is to work as part of an integrated midwifery team providing the highest quality midwifery care in both high and low risk settings. They are expected to regularly contribute to an on-call rota that supports a continuity of carer model and to complete a preceptorship programme within a negotiated time period.

The key result areas and responsibilities include assessing the health and wellbeing of women and babies during all stages of pregnancy and the postnatal period, to plan, deliver and evaluate evidence based care for women and infant feeding support for babies both within the hospital and community setting. Establishing and maintaining communication with women, relatives and other members of the maternity team including difficult and complex manners, promoting the equality and rights for women, their families and all colleagues by actions which support diversity, being non-judgemental and challenging discriminatory behaviour from others.

Band five midwives have either recently qualified from university or are within 12-18 months post registration. They will be in the process of completing a period of preceptorship and when assessed as having completed, they progress to band six.

7.6 Band six midwives

The majority of midwives working within this maternity unit are at band six level, their experience varies according to how many years post registration they are, the university they attended, what years they trained and what professional training they have undertaken throughout their professional career. The job description analysed here was undated. The job purpose and key result areas for patients are the same as band five expectations but with some additions. A band six midwife is expected to teach antenatal education classes to groups of 30 parents, they are also required to be a named midwife for a nominal group of women to whom they provide antenatal care with support from a senior, band seven midwife. An element to the person specification for an experienced midwife, regarding infant feeding, is a requirement of at least two years' experience of providing support with breastfeeding.

7.7 Band seven midwives

There is not a natural progression into a band seven role, these positions are advertised and appointed following interview. Band seven midwives have various roles, including specialist midwives for example BFI lead midwife, bereavement midwife, safety midwife and midwives with management responsibilities for an area within the unit and those who co-ordinate the daily 'running' of the antenatal and labour ward or the postnatal ward. The job description and role responsibilities are less clinically specific, they have the same basis as a band five and six regarding assessing the health and wellbeing needs of women and babies at all stages of pregnancy and the postnatal period and to plan, deliver and evaluate a high standard of evidence-based care for a caseload of women. Their responsibilities become policy and service development based. There is no specification or discussion of infant feeding experience as a requirement.

There is a current job description for a band seven BFI lead midwife. The job purpose for that midwife is to lead on the strategic planning, implementation and

maintenance of the UNICEF BFI standards across the maternity service within this NHS trust. The BFI lead is responsible for training staff, audit and data collection to ensure that best practice standards are maintained within the maternity unit. The development of guidelines and policy on infant feeding are required in the role. A key part of the role is to lead and progress the BFI accreditation "project" to full achievement ensuring the maintenance of the BFI to ensure local breastfeeding initiation and continuation rates improve.

7.8 Band eight midwives

The band eight midwives form the senior midwifery management team, within this NHS trust. They work clinically for at least one shift a week and it is an expectation that they all work in this way. The band eight team consists of, but not exclusively, the associate director of services, an antenatal and labour care matron and one matron/clinical leader who leads community midwifery, public health and postnatal care. The updated job description for this latter role states that they are expected to lead on all aspects of the community service, management and promotion of breastfeeding including BFI and they will oversee and lead on public health campaigns. Regarding the BFI, the key result area is to lead on the promotion, training and support of breastfeeding and maintaining the UNICEF Baby Friendly award. An education and training package for the band three support worker team is also to be developed.

Chapter seven discussed the document analysis findings regarding the formal allocation of infant feeding support responsibilities by job band in the study maternity unit. A hierarchy emerged where lower bands have task-oriented duties and higher bands have more complex clinical and managerial infant feeding roles. The band two support workers provide basic infant feeding "advice", the band three team provide detailed "support", all midwives have clinical care responsibilities and band seven and eight staff provide strategic BFI leadership. Reviewing these formal role expectations contextualizes the real-world experiences of maternity staff implementing BFI standards in this setting. Comparing documented responsibilities, expectations and actual practice highlighted BFI implementation barriers and facilitators. This enabled the researcher to contextualise the expectations for participants from different

bands when supporting and implementing the BFI standards into clinical practice. What has emerged from the document analysis is that there is a lack of clarity regarding UNICEF UK BFI responsibilities for band five, band six and band seven midwives.

Chapter 8 Qualitative research findings

8.1 Introduction to chapter

Chapter eight provides the research findings. The aim of the study was to identify the barriers, challenges and facilitators to successfully implementing the BFI standards within a maternity unit. The study objectives to meet the aim were to explore the views and experiences of maternity staff when working with the BFI standards in practice, and to explore the views of infant feeding lead staff members and midwifery managers regarding the implementation of BFI standards within their maternity organisation.

This study has explored infant feeding support training for midwives and maternity support workers at the case study maternity unit with the aim of identifying what the barriers and facilitators are to successful BFI implementation. It examines the training background from the local university, workplace training provisions for midwives and maternity support worker training. The analysis highlights variability in prior knowledge and ongoing education which has implications for consistent, evidence-based infant feeding support (section 8.3).

Section 8.4 provides an in-depth examination of staff knowledge surrounding infant feeding support and the BFI standards. It explores how knowledge is obtained, differences in knowledge between staff groups, BFI training provisions, integrated care impacts and preparations for the BFI re-assessment visit.

Section 8.5 explores the theme of time and how it impacts infant feeding support provision. It examines time allotted for training, time pressures in caring, hospital versus community time differences, staffing levels and time and the development of band three support workers to mitigate time constraints.

The promotion and support of breastfeeding is a key priority for maternity services. In the UK the BFI provides a set of standards and an accreditation programme for maternity facilities to support breastfeeding and promote close and loving relationships between parents and their infants. However, there are ongoing challenges in implementing BFI standards in practice within the study

site which the objective of exploring staff views and experiences aimed to highlight. A key theme explored is the perception of responsibility for providing infant feeding support amongst different staff groups - band two maternity support workers, midwives, and a team of band three senior postnatal support workers. The band three team were originally introduced as a dedicated resource with protected time for infant feeding support. However, their role has expanded over time to include other clinical tasks. Reasons for referral between staff groups and the rationales given for referring to the band three team or avoiding providing direct feeding support include lack of time, lack of confidence or no interest in providing support. This highlighted inconsistencies in infant feeding training, knowledge and attitudes across groups which are barriers to BFI implementation. There are clearly challenges in implementing consistent, equitable support for mothers within the current staffing model.

8.2 Participant overview

Below is an overview of the maternity staff participants, of which there were 17. In order to maintain confidentiality and anonymity, pseudonyms have been applied and they have been broadly categorised by staff group.

Table 4: Participant overview

Participants by staff group and pseudonyms (Total = 17).		
Senior maternity staff incl. midwives and managers	Registered Midwives incl. band five & six	Maternity support workers incl. band two & three
Joan Jules Rose Tania Vicky	Elaine Jean Julia Lisa Ollie Penny Perry Wren	Abby Ann Betty Daisy

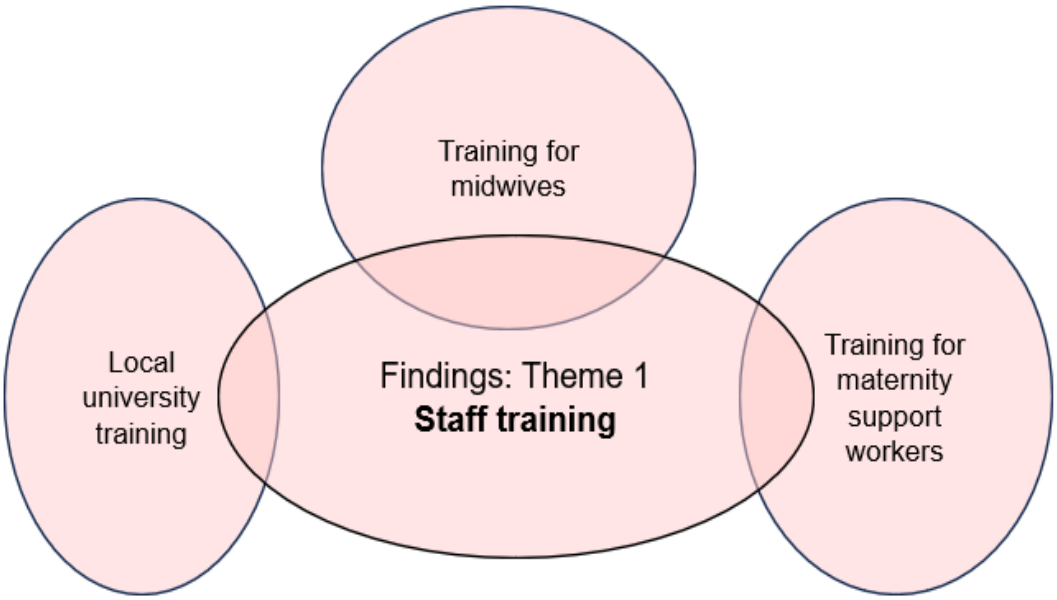

Figure 8 Findings theme: Staff training

8.3 Staff training

This section discusses staff training regarding 1) Local university training for midwives 2) Workplace BFI training for midwives, the reasons for a lack of BFI training and staff views regarding this and 3) Training for maternity support workers. What infant feeding support training band two and band three maternity support workers are provided with is discussed along with what infant feeding support expectations there are of each staff group.

8.3.1 Local university training

Many midwives employed at this maternity unit have completed their midwifery training at the same local university. Therefore, the BFI accreditation status and training resources developed by the university are discussed first.

Midwifery participants explained how university BFI training was very in depth, but since their employment at the study site they no longer felt their BFI knowledge was current. For some midwives, the only BFI education they had was at university, which was very comprehensive and benefits those who have recently qualified as they felt up to date with current evidence:

> "I've had fairly comprehensive training at university which wasn't that long ago so I would like to think it's fairly fresh in my mind" (Wren)

Jean also attending the same university as Wren and discussed that there was a clear process for BFI education and accreditation however when commencing her employment with the trust, she felt that she was unaware of the status of the BFI within the maternity unit and felt that she had personal BFI accreditation as opposed to having general knowledge of the standards:

> "I don't know much about the hospital, uni had us achieve certain things for us personally to have our own accreditation whereas in the hospital it is more of a general…everybody needs to know bits" (Jean)

The midwifery degree course is accredited as Baby Friendly (BF) which demonstrates that the UNICEF UK BFI standards (UNICEF UK 2013, 2017) and Achieving Sustainability standards (UNICEF UK 2023) have been incorporated within the university curriculum. These standards ensure that there is:

> "a strong foundation for embedding and progressing the Baby Friendly learning outcomes over time with the long-term aim of improving the health of babies, their mothers and families".

Participant Jean is one of two midwife participants who had graduated from this university within the last five years who spoke of having their own accreditation status, however they were unclear as to the meaning of this. They questioned if it was a personal title that could be used throughout their career or whether accreditation was throughout their degree course; "I'm not sure if it's just a year-long accreditation or if I've got it for life" (Jean). There is no personal accreditation status or accreditation for individuals, it is the midwifery degree course that is UNICEF UK BFI accredited.

Midwifery students who achieved a high pass mark for the infant feeding elements of their degree became a 'champion' although this participant was unsure what this title meant or like her colleague above, questioned if the title was relevant for her now in clinical practice:

> "[I] became a champion, I'm occasionally asked to help with the testing of students doing their assessments. I don't know how that stretches through though, whether I can keep that tag or not" (Lisa)

This university has developed an online resource package which covers all aspects and evidence regarding infant feeding and supporting close and loving relationships between parents and their baby. Most participants of this study were aware of the package as it was included in their degree curriculum and was used within NHS settings, but there were occasions where maternity and neonatal unit staff could not recall the name.

8.3.2 Training for midwives

A plan for maternity staff education within the trust was to incorporate the university online package into staff training requirements, it was viewed as an evidence based, substantial package which, when staff had completed it, would be supported by a face-to-face in-house training day, facilitated by BFI team staff:

> "[the package] is very fact based, very, very substantial and then we'd have a sort of catch-up day afterwards" (Tania)

The training plan that was agreed by midwifery management was that all maternity staff, midwives and maternity support workers, were to complete the package in their own time and seven hours would be 'repaid' to them through their work rota. There was a feeling amongst a handful of participants that this was the main infant feeding training for all maternity staff who provide infant feeding support to women and must be completed prior to any clinical care being provided. This requirement to complete the online package is not documented in any staff job descriptions yet completion was considered an expectation for band three senior postnatal support workers.

When joining the band three support worker team, Abby discussed that newly employed staff received a password to access the online package as it had been identified as a requirement of their role and an element of their hospital trust induction, although there was no set timescale for completion, only "encouragement" to do so. Due to the large amount of information in the resource and the requirement for staff to have hours paid back to them for completion, it was viewed as a "big investment in management's time and budget" (Ann). Some maternity support workers found there was too much theory and subsequently did not complete the package and whilst midwives did

not ‘struggle’ with the facts, some found the non-midwifery material difficult to consider important. The resource package was regarded as excellent by those who were keen to complete it, but it appears that many midwives did not see the importance of it:

> “The package was too difficult for everybody. It went on longer than being midwifery based and some people struggled to see that as important” (Tania)

There was a lack of clarity amongst maternity staff as to who was responsible for monitoring the completion of the package. There is one member of staff who can provide access and whilst she was certain that this was her responsibility, another two participants were unsure and gave the name of each other. There was no one identified with responsibility for monitoring who had been given access to the package and completed it. Participants felt that the responsibility was that of an infant feeding lead who should be fulfilling that role:

> “Whether anybody actually goes through and checks…I don’t know. I presume the infant feeding lead is doing it” (Abby)

With the differences between staff understanding of all the elements of the resource package and an apparent lack of monitoring, the training plan deteriorated; the plan to provide a face to face follow up training day once the online package was complete did not become established. The utilisation of the resource package for training and following up on staff knowledge was never revisited by midwifery management.

The online resource package is used in neighbouring NHS trusts in a bid to ensure that all staff have gained the same level of BFI education so that consistent infant feeding information and support is provided. It appears to not have been overly accepted in these areas as the terminology uses is interesting: “we were hounded to complete that package” (Jules).

A group of midwife participants who attended the same university, albeit at different times, stated that they had gained a wealth of in-depth BFI education at university but that BFI training since qualifying and commencing employment had been absent. There are midwives working at the study site who graduated prior to the university gaining UNICEF UK BFI accreditation and although they

did not receive specific BFI training, they were expected to complete a breastfeeding competency booklet as discussed. Rose spoke of how this booklet was not officially marked and therefore students would meet and fill in the booklets together, often copying from each other. Some midwifery participants graduated from university with a passion for infant feeding, unfortunately they feel that their knowledge has declined. The reason they provided is non-existent BFI education and training in the workplace.

Midwifery and maternity support worker participants who are passionate about the BFI will refer to it when speaking to colleagues. There are midwives who make it clear that they have no interest in the BFI standards and are reluctant to provide care for breastfeeding families. Lisa feels that referring to the BFI evidences her knowledge and care and aims to increase their understanding as well as highlighting to them that she is not 'making things up':

> "I'll refer to the BFI if I'm speaking to colleagues so that they don't just think it's me spouting…I think some people roll their eyes at me. It's a cultural thing, there's a lot of self-bias that happens, with midwives and support workers still being seen as the breastfeeding Nazis" (Lisa)

Lisa explained that, although she tries not to be, she feels like a 'breastfeeding Nazi' when discussing breastfeeding with some colleagues and explains the research evidence to them in a bid for them to not view her as spouting her personal views or opinions.

Since 2016, BFI education training and annual updates was gradually removed from mandatory staff training, midwifery management participants explained that the reason for this was that they were not meaningful enough to warrant the time needed to deliver it. Prior to removal, staff would attend local training sessions in the trust education centre, this consisted of one day face-to-face training followed by yearly update sessions. This was seen as effective training:

> "Time is precious on mandatory training, so it needs to be meaningful. We used to do midwifery updates and it was excellent" (Vicky)

When BFI annual updates were mandatory, there was a midwife employed as the breastfeeding lead who was viewed as proactive and was the member of

staff to approach regarding the BFI and any infant feeding related information. Participants found her to be very active in leading the BFI education programme however when she retired, she was not replaced. It was then noted by staff that the BFI training and standards declined, and training became ineffective:

> "It's clearly not stuck in my brain [breastfeeding/BFI training] so no I wouldn't have said that it's been that fabulous, it's been poor. I feel that over the last however many years the BFI has dropped off the radar" (Ollie)

Midwifery participants who have worked at other NHS trusts noted differences between their previous workplace and the study unit. Maternity units that have achieved BFI accreditation status have a constant and robust process for staff training and updating which is missing at this unit, it was felt that there was no structured, official training and staff felt they were left to their own devices resulting in midwives providing feeding support on an ad hoc basis:

> "The lack of training erodes the messaging, people go off piste and do their own thing, the midwives are doing everything ad hoc where the band three team are very good at delivering the key messaging" (Joan)

Those who have worked at other NHS trusts state that the BFI training schedules consisted of two full days of education with annual updates and bimonthly-quarterly meetings. Following these meetings, updates were given to team leaders who disseminated feedback to their midwifery team. As BFI education and training is absent from mandatory training at this unit, Julia feels that it suggests a lack of support for the BFI:

> "I have never had any training here, it's absent from the mandatory training, there's no obvious support for the BFI" (Julia)

Most participants felt that staff training is required, which would ensure that all staff are educated and disseminating evidence-based information ensuring that care and advice is consistent. There was a suggestion by participants that having staff who were willing to be open to accepting the BFI standards and "knocking down some [of their] walls", infant feeding education would open their minds and horizons, but the process would be lengthy:

> "I think once staff get training you can open their minds and their horizons but it's gonna take a long time" (Lisa)

Julia felt that BFI training should be provided to the hospital as an organisation:

> "[education] for all staff [within the hospital], not solely maternity staff, would assist with embedding the BFI principles and standards throughout the trust as a whole".

Senior staff participants were well placed to discuss the multifactorial reasons behind the removal of BFI education from mandatory training days and updates. The main reason provided by managers was because the BFI "too costly" and UNICEF UK had a "monopoly" on what they described as an "extensive agenda". It was suggested that UNICEF UK were asking for far too much money. This resulted in a reluctance to spend "a huge amount of public money" when there was a potential for receiving national funding. With the potential of a national steer towards the BFI (UNICEF UK 2017) and the maternity unit being provided with funding (UNICEF UK 2020), management decided to 'wait out' and made the decision that the BFI was not a priority for staff education at that point in time and focussed maternity staff training on national safety agendas (Parkin and Balogun 2023).

NHS trust executive boards rely on the director of each service to highlight their priorities, the priorities that are not promoted by maternity managers will not receive funding. To provide maternity staff with training, directors of midwifery at surrounding NHS trusts, including the study site, had a discussion about developing their own infant feeding teaching package and self-assessment tool so that the same information that was provided by UNICEF UK BFI could be delivered to their staff. However, senior midwifery participants informed me that they were informed by senior staff at NHS England that local packages could not be developed and that the only acceptable education and assessment programme was that from UNICEF UK. This served to reiterate the feeling of there being a monopoly:

> "I think they do have a monopoly but that may be because it's really good, UNICEF makes a vast amount of money out of it, but they are a charity so that's good…umm…" (Vicky)

Not all senior staff are convinced that the BFI makes a difference to families and that occasionally the guidance was not useful, leading to cynicism. An example given was 'the hands-off' approach to feeding support, reiterating the requirement for an enthusiastic leader of the BFI being required to ensure delivery of the correct message:

> "Sometimes the guidance wasn't useful, you know the 'you must never touch the breast', it was quite tricky because sometimes you felt you just wanted to get the baby on the boob" (Vicky)

Midwifery managers stated that the BFI is a big initiative which could not be adequately funded and subsequently became hard to continue to implement, this resulted in the removal of it from staff training. Vicky described it "as being delivered in a vacuum" by staff to their colleagues on an ad hoc basis and so the decision was made to remove BFI training completely.

8.3.3 Training for maternity support workers

Many of the band three maternity support workers at this trust have completed breastfeeding peer supporter/counsellor training prior to their employment with the NHS, these courses were facilitated by the Association of Breastfeeding Mothers (ABM), Real Baby Milk, and the National Childbirth Trust (NCT). Those who have completed these courses did so at their own expense and in their own time due to a passion and personal interest. Daisy began to oversee a feeding support group which she attended with her own baby, but admits that the information they discussed at the time was not based on BFI principles:

> "I went with my own baby and then I ran the group, it was a voluntary opportunity…I don't know where the information was from but none of it was specifically BFI driven" (Daisy)

The decision for some to access training and self-fund is linked to their future career aspirations:

> "I paid for it [training] myself to help me along…I like to keep studying so if I can get some formal accreditation behind me, who knows what the future brings" (Ann)

A handful of participants had completed peer supporter training with the NCT and while some of the training was felt to be different to UNICEF UK BFI

(UNICEF UK 2017), Tania feels that the information from the NCT linked with the BFI standards, suggesting that the BFI has become like NCT theory:

> "The NCT is completely separate from UNICEF, it's much more substantial and it's a lot more on how you relate to people…you can see where some of the stuff [BFI] comes from but it's the other way round, BFI has become more like NCT" (Tania)

Once employed, the training that seemed to be expected of the band three support worker team members was the online package developed by the university. They had an opportunity to meet with the infant feeding lead staff member once a year, for one day, however that was merely an update to discuss problems that had been encountered in practice that they wished to discuss. It was not BFI focussed discussion and was not classed as training. The education, training and knowledge history of this group of support workers is unknown amongst the midwives. There is a presumption that they have had BFI training at some stage in their career, certainly an expectation of those who were employed at this trust when they had BFI accreditation. This leaves a cohort of band three support workers who have commenced employment since accreditation lapsed and so, within this team, there are those who are maintaining their 'older' knowledge and those with no training and possibly no knowledge. Any training they may have, would be what they have sought themselves:

> "There'll be an element of self-training, there'll be what has been instilled here [maternity unit] and some from the past as well" (Joan)

Midwife participants openly admit that they do not know what BFI education maternity support workers are provided with. One participant questioned if support workers are receiving BFI training that midwives are not. Maternity support workers also have no regular BFI training opportunities. When midwives are questioning if support workers are provided with education as a priority to them, this opinion could have a negative impact on how support workers are viewed and may impact professional relationships.

Midwives have various expectations of the level of feeding support expected from band two and three maternity support workers, but neither support worker

groups have any regular BFI training. Brief, practical skill teaching sessions have been arranged in the past by support worker managers in response to support workers complaining about lack of knowledge and skills. Betty has felt like she is letting down her midwifery colleagues as there have been occasions when she has been asked to assist families with feeding support. She, alongside some of her support worker colleagues have had to refuse midwives, giving them a feeling of not fulfilling their professional role:

> "When I get asked to help with feeding support, I have to say I haven't had any training on that, we are all very keen on doing more" (Betty)

It is positive to hear that their voices are being heard by their managers and that training is being arranged however it was felt my support workers to be short in length and felt very rushed.

There is an expectation of the band three support workers to provide extensive infant feeding support, it is a requirement of their job role. The experience of those having completed previous training at peer supporter or counsellor level should be utilised. Feeding support that is expected from the band two support workers includes assisting mothers with basic information about feeding their babies such as demonstrations for the safe preparation of formula feeds, assisting with breast pumps and the correct use of cups and syringes for feeding when required. They are also required to have basic knowledge of the UNICEF UK BFI standards (UNICEF UK 2017). With the band two job description in mind there is also no regular BFI training for this staff group, no one takes responsibility for teaching them how to safely prepare formula feeds or to show them the correct cup and syringe feeding techniques. This highlights a gap between what is expected from the team and the knowledge they have, they are not taught how to correctly complete these 'tasks', being left to their own devices to learn how to fulfil these job role requirements:

> "I've picked things up as I go along, I've learnt by reading packets, using common sense, bits I've picked up from the ward but actually I was clueless when I started" (Wren)

Shortly after her employment commenced, Abby was aware of a band two support worker demonstrating the safe preparation of formula to a family and so

took the initiative to watch her colleague. This aspect of feeding support is not specifically stated in the band three job description however she was actively seeking her own learning opportunities.

Within this maternity unit there is a general feeling amongst staff that every staff member should be trained in providing infant feeding support and that the majority want to learn and complete BFI training. Band two support workers told me that they want to gain confidence and to know that the care and advice they are providing is correct and evidence based, they recognise that their job is to assist both the midwives and families and whilst the majority are keen for training, it is not a universal feeling. There are band two support workers who say that providing infant feeding support is not their job and this has been heard by their colleagues:

> "I know there are some staff who aren't keen to do it [feeding support] but the majority do, some say it's not their job…I'm being really mean but that's what they say" (Betty)

Betty feels bad about what she is saying about her colleagues, she is being honest about what she has heard, but there is a sense of betrayal towards them. Other staff working with the band two support worker team, have also heard what has been said. They are aware of this tension and feelings from those who state, it is not their job, they are not trained or are reluctant to provide feeding support:

> "It's not all of them [band twos] but I have heard in the past…I don't do breastfeeding'…actually we aren't asking you to do it, we're asking you to support it" (Ann)

This attitude was found to be challenging to some participants and Penny suggests that such reluctance from support workers who are not pro breastfeeding use the excuse of not being trained so they do not have to support families:

> "I have found that's challenging maybe, the attitudes of other people…you're kind of up against it a bit" (Penny)

Band two support workers who may lack confidence in feeding support or those who generally do not want to do it and state that they 'don't do breastfeeding' is

not tolerated by some of their colleagues. For Ann, she feels that this attitude has no place within a maternity unit as staff are there to support the families.

> "I don't do breastfeeding has no place in maternity I'm afraid, it's not about you, if you feel like that about breastfeeding, sorry, I might be speaking out of turn, but you shouldn't have a job in maternity…regardless of your band we all need to support with feeding" (Ann)

These quotes demonstrate that a range of staff within the unit are not comfortable when band two support workers refuse to assist families with infant feeding support and go so far as to say that they should not have a job. Having no interest or no confidence is not accepted as an excuse by many.

I was, however, provided with examples where band two support workers were described as very proactive, "some were absolutely incredible on a night" (Perry), and viewed as integral members of the team who require recognition, especially during a night shift where midwives felt that band twos, on occasions, were providing the care that a midwife should be. Midwifery staffing numbers during a night shift is regularly less than a day shift. This is due to the requirement of daily examinations of mother and baby which are completed throughout the day and any medical reviews that are warranted and so this explains why midwives feel that their feeding support roles are being completed by support workers at night.

There is regular 24-hour band two support worker cover within the unit, this is not the same for the band three support workers. Band three staff work a variety of shift patterns which suit their personal requirements, very rarely is there a team member present on the late shift (13.30-20.30hrs) and they never work for the whole night shift (20.00-08.00hrs). Since there are only band two support workers present throughout the night, and that they are viewed as integral within the maternity team as a whole, there may be an over reliance or higher infant feeding support expectations on them. They are required to volunteer for access to complete the online resource package, this is not a job requirement for them however some of their colleagues feel that it should be incorporated into their role:

> "The online package is not seen as part of their role but actually as they are here overnight you'd think it should really kind of be incorporated a little bit" (Abby)

There is sympathy felt by midwifery management towards the band two support workers and that the expectations of them must be clear and realistic, they should not be expected to provide the same level of support as a band three. Managers felt that infant feeding practicalities and rudimentary advice is the requirement in their role, not to be feeding support experts. Occasions were described when a band two support worker has witnessed a midwife not providing feeding support and waiting for a band three to become available:

> "They are seeing midwives saying…oh I'm gonna wait for and infant feeding team member" (Vicky)

One midwifery manager participant stated that when this is the case, it is unrealistic to expect them to do the job and not mimic the midwives by referring to a band three.

8.3.4 Conclusion

8.3.4.1 Local university training

Most of the midwives who work within this maternity unit have attended the same university, resulting in cohorts with a high level of BFI knowledge owing to the university's BFI accreditation status. There is confusion regarding 'personal' accreditation and being a breastfeeding 'champion', these are not professional titles that midwives carry within the workplace. The online package developed by the university must be completed by midwifery students throughout their midwifery degree.

8.3.4.2 Training for midwives

This section has highlighted that many midwives in this unit have attended an accredited university and have an in-depth underlying knowledge of the BFI however in time this knowledge is becoming vague and outdated due to lack of workplace training. Over recent years BFI training has been removed from mandatory training, the suggestion being that it was not meaningful to staff and therefore did not warrant the time for staff to attend. When there was an identified BFI lead midwife there was a positive feeling regarding training

however when this midwife left the role, she was not replaced leading to staff feeling like the BFI dropped off the radar within the unit. In an attempt to keep knowledge updated amongst colleagues there are some midwives who will discuss the BFI and refer to it to support their advice but this is occasionally met with eye rolling.

There is a notable difference in training schedules for staff between different NHS trusts and when there is not constant and robust training there is the risk that staff will go 'off piste' and provide infant feeding support on an ad hoc basis. When the BFI and staff training were discussed with senior maternity staff the main point identified was financial constraints. The feeling is that UNICEF are asking for far too much money leading to a reluctance to spend public money on the agenda. For funding to be available for the maternity service, the executive board must be made aware of priority agendas, this did not happen at the trust in 2018 possibly because some senior staff are cynical about the guidance even suggesting that it is useless. Due to lack of funding and no support for local packages, the feeling of UNICEF having a monopoly, staff training was removed from mandatory training.

8.3.4.3 Training for maternity support workers

What this section demonstrates is that there is no one level of training for the support workers within this maternity unit. The peer supporter training from associations such as the ABM, Real Baby Milk and the NCT also differ. It has been identified that there is a variation of infant feeding support skill set amongst the maternity support workers ranging from those with in depth training gained prior to NHS employment to those with little knowledge and questionable willingness to participate in feeding support. There is a difference of opinions within the band two team regarding feeding support. Some staff are very proactive and eager to increase knowledge in this area. This will enable them to fulfil their role of assisting the midwives but also to provide evidence-based care to families rather than relying on their own personal feeding experiences. Others band two support workers state that providing feeding support is 'not their banding' or job role, when in fact it is stated in their job description that they are expected to provide rudimentary advice in the practicalities of the safe

preparation of formula feeds and breastfeeding support. Band threes and midwives state that band twos should provide feeding support due to their presence during a night shift however there is a question as to why the band three team do not work night shifts.

The band three team are viewed as experts within their role due to their assumed infant feeding knowledge and whilst there are those who have peer supporter training there are many of them who have not and have had no BFI training at the trust, all members of the maternity staff seek the 'expert' advice of the band three team.

Staff knowledge regarding the BFI accreditation history and training process within this unit is minimal, those who participated in this study were only aware of the topic following advertisement of the study and discussion with peers.

8.4 Staff knowledge

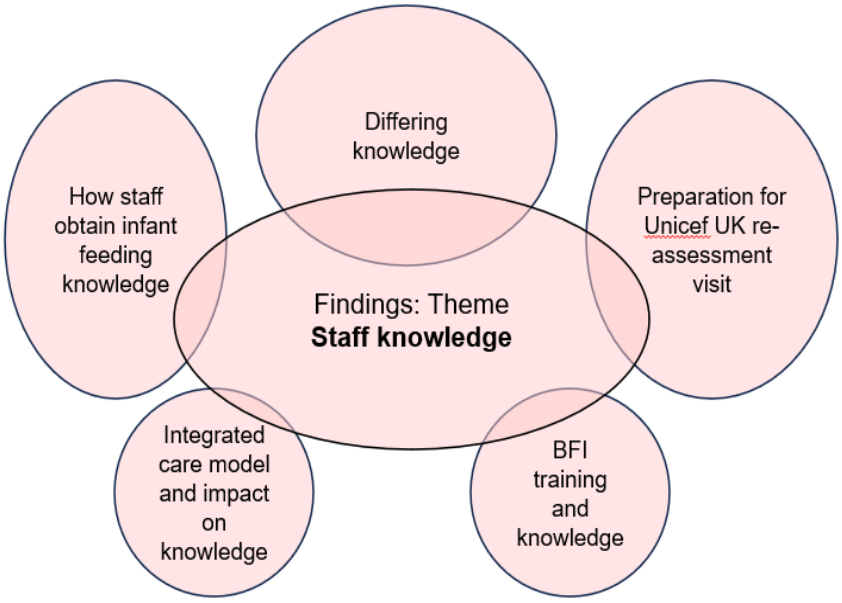

Figure 9 Findings theme: Staff knowledge.

This section of findings presents 'Staff knowledge' which looks at the following themes 1) How staff obtain their infant feeding knowledge, 2) Differing knowledge, which highlights how knowledge differs between NHS maternity units, universities and staff who work day versus night shifts. Working within the maternity unit and the differences between this area and the community setting will be discussed. 3) BFI training/knowledge, identifying who has

responsibility for staff training to ensure there is a consistent level of understanding amongst staff, 4) Integrated model of care and impact on knowledge briefly discusses the benefits and problems of working within this care model and finally 5) Preparation for UNICEF UK re-assessment visit.

8.4.1 How staff obtain infant feeding knowledge

Many participants told me that they were aware of breastfeeding principles of positioning and attachment, hand expression of breastmilk and safe preparation of formula feeding due to having their own children and self-learning these techniques. Having had these experiences first hand is the foundation that some maternity staff build their confidence from. Prior to the BFI being introduced into maternity units, and before she became a member of staff, Betty felt that infant feeding support was initially a very hands-on approach before being left to learn the skill of breastfeeding herself:

> "It was more hands on when I had my children, I can remember them [midwives] grabbing my boob and putting it in the babies' mouth, after that [with subsequent children] it was more self-taught". (Betty)

This hands-on method was discussed by Daisy who had experiences of women who have told her that they felt disinclined to continue with breastfeeding following assistance with positioning and attachment which involved the midwife grabbing the breast and physically hand expressing breastmilk.

Personal self-taught knowledge is the only knowledge that some maternity staff have, this is what is being offered to families in their care. Occasionally staff are providing information that they have either overheard their colleagues say to mothers or where feeding practices are generally discussed within the maternity unit. Listening to these general conversations and then providing information to mothers, which may also be influenced by their own feeding choices, could result in non-evidence-based care provision. Alongside this care, staff sharing their personal feeding experiences leaves women with a feeling of receiving conflicting or confusing information due to the many different personal experiences of staff, some participants discussed that women may be unable to process many different stories or 'helpful tips', highlighting why a consistent evidence-based approach to care and provision of information is required.

Midwifery management have made it clear to maternity staff that it is professionally unacceptable to 'tell' women their infant feeding stories, even when personal advice may be thought to be helpful:

> "I think some people will have a very good personal experience and they'll think 'this worked well for me'" (Jules)

Participants felt they are placed in difficult situations when mothers report they have received seemingly conflicting advice. It was suggested that how feeding support information is delivered may give women the feeling that it is conflicting or when small chunks of advice are given it can feel like lots of different suggestions, but that staff are all saying the same thing. Daisy uses a tool-box analogy when offering explanations to mothers:

> "When women feel that they've had loads of different advice I try and use the tool-box analogy about how we have different tools but it doesn't mean we can't work towards the same goal". (Daisy)

There must be something going awry if regular feedback from women is that infant feeding messages are inconsistent, staff may be "singing from the same hymn sheet" (Ollie) but possibly it is the communication style of maternity staff which needs to be adjusted. The BFI is clear regarding the information to be discussed with women and their families (UNICEF UK 2017) therefore all maternity staff should deliver this consistently, however, the woman's perception of what she is being told, how it is phrased, the questions they are asked and whether there is an element of sleep deprivation, are factors that participants have suggested will have a bearing on how information is received:

> "The BFI gives step by step guides for professionals so that women are hopefully getting consistent advice, I know feedback says it's not but I think that's possibly women's perceptions, they don't always take it in first time, they don't always hear everything, they're not always paying attention" (Wren)

There are midwife participants who are burdened with their own embodied experience in relation to their personal infant feeding experience. What remains unknown is whether they have encountered difficulties and challenges, or if their feeding journey ended in a way they did not expect or earlier than anticipated.

This has potential to result in a negative view of breastfeeding with subsequent unwillingness or lack of confidence to help women, which not only impacts care they provide but will result in them becoming deskilled in infant feeding support. This deskilling will be further impacted owing to a lack of staff education and training. All maternity staff should be offered time to reflect on their personal issues with breastfeeding and their own feeding journeys to ensure that they are not approaching care with any bias that may be impressed onto families:

> "There might be some personal issues about breastfeeding, this is where we reflect on our experiences, so they aren't brought into the workplace, it's about evidence base and not using your own feelings" (Ann)

Many participants discussed that there are personal views surrounding the topic of infant feeding, they do not feel that this is negative, but they acknowledge that it must not negatively impact the ability to provide effective care and support. Staff can be defensive about the topic of breastfeeding, whether that is due to their own feeding choices or if they generally have no interest. Examples provided by study participants were of colleagues providing formula milk to breastfed babies as they had no interest in providing breastfeeding support:

> "Lots of personal views isn't always a bad thing, but some [staff] feel that somehow giving honest information…there has been an incident where formula was given because she [support worker] personally can't be bothered to give feeding support" (Wren)

Two participants, Jules and Elaine are members of staff who work within the Special Care Baby Unit (SCBU) who both discussed similar themes. There is a lack of awareness of the BFI standards amongst senior and most ward based staff within the unit which demonstrates a lack of managerial support in highlighting the benefits of the BFI and human milk to staff, there is also a lack of training opportunities for this staff group:

> "I haven't come across any formal training opportunities" (Elaine)

During the interview with Jules they stated that the team knew that "breast is best" and that breastfeeding was always supported and encouraged, using this

phrase however is outdated which questions how up to date Jules is with their own evidence and knowledge.

It is not only within the maternity ward where formula milk use is viewed as beneficial when compared to breastfeeding. By the very nature of a baby being admitted into the SCBU, they are requiring a higher level of care as opposed to the maternity unit and the majority of them have been commenced on a feeding plan, as directed by paediatric consultants. These feeding plans are clear with set amounts of fluids/milk that an infant must have, the amounts are titrated by age and weight. The message that is given to parents is that in an aim to be discharged home, the baby must gain weight on a plan of "15 grams per kilogram of birth weight per day" (Jules), using formula milk to follow this plan is viewed as being "easier" for SCBU staff:

> "It's a lot easier in a drip or in a bottle of milk…just because you can" (Elaine).

If the daily target is not met, the baby is deemed as not gaining an "appropriate weight and therefore does not have proper growth", which is seen as an "unsafe situation" (Jules). Jules also discusses that SCBU staff "prefer to use food rather than an intravenous solution" to provide nutrition to babies and for those who can tolerate oral fluids then they should be provided with milk. In these circumstances it can be "a variable feast" (Jules) as to whether babies receive donor expressed breast milk (DEBM), maternal breast milk or formula milk, particularly for infants who are at a high risk of necrotising enterocolitis, which is a potentially fatal gut infection, for which human milk offers protective factors against (REF). With a lack of routine and regular access to DEBM and a general preference for food versus intravenous nutrition it may be questioned as to whether parents feel pressure to provide their infant with readily available formula milk to ensure that the weight gain requirement is met. This decision by parents may be welcomed by staff, even more so if there is a personal lack in confidence with breastfeeding support:

> "I'd say there's more bottle usage on SCBU, i think staff are more comfortable with a mum who decides to bottle feed from birth because

> it's a lot easier and that's where their knowledge is, whereas breastfeeding…I don't know if there's as much confidence, there's less confidence when you've got a breastfeeding mum" (Elaine).

Lack of staff confidence and a prescriptive feeding plan could impact the choices that parents make regarding feeding method. Jules felt that there are staff and mothers who feel pressured by midwives and maternity support workers to breastfeed or at least make one feeding choice over another. There is an underlying feeling that this creates a barrier between the maternity unit staff and SCBU staff, Elaine spoke of how there is a feeling of dislike towards them from maternity staff:

> "I think there are probably members of staff that feel like midwives don't like us…I don't know…I haven't heard a huge amount of midwives say anything bad about SCBU" (Elaine)

Whilst Jules acknowledges that there are strong personalities amongst staff this may create a barrier, but they do not think there is a barrier between departments:

> "There are personality issues that are in play, that is still a very big barrier that is not real" (Jules)

SCBU staff feeling that maternity staff pressure parents could be viewed as being slightly contradictory, as it was discussed that pressure to be quickly discharged home from SCBU leads to parents deciding to formula feed as an easy choice, especially as there is a lack of training and staff confidence with breastfeeding and the BFI standards. There are SCBU staff who have experience supporting breastfeeding mother and baby dyads however this support is can be variable:

> "The level of support that everybody [staff] will give is variable as training is not consistent amongst the team and people come with their own experience, own biases and their own preferences…that's a difficult thing to change" (Jules)

What this section demonstrates is that both maternity and SCBU staff have their own guidelines and infant feeding support and care that they provide, which they believe to be in the best interests for the mother and baby dyad. At times this care differs for which each staff group could disagree with, forming what is felt to be a barrier between them. There is a lack of training and experience which applies to both staff groups within this trust.

8.4.2 Differing knowledge

There is a vast difference in BFI knowledge amongst the maternity staff at this unit. There are differences between the maternity support workers and midwives who have only worked within the study unit but there are differences present where midwives have worked in other NHS hospitals and trained at different universities. Midwives who have been educated at BFI accredited universities and/or have worked within accredited maternity units demonstrated a clearer, up to date knowledge base of the BFI standards. Conversely there are several midwives who have completed their midwifery training prior to the publishing of BFI standards and have not attended any workplace training. Elaine identified this as a challenge as these midwives are difficult to approach to discuss current evidence. When they have been working within a maternity unit for many years they are either viewed as very experienced or 'stuck in their ways', they have the opinion that 'this is how we've always done it':

> "It can be difficult to pull someone up who has been working there for 20-30 years and to try and bring to light the up-to-date evidence…it can be challenging, it's hard to change the attitudes" (Elaine)

There is a general feeling within this unit that there is a variation in knowledge between staff who work day shifts versus night shifts and that care is provided differently within the hospital versus the community setting. Throughout a long day shift or the shorter early shift (07:30-20:00 or 07:30-14:30), there is a postnatal lead midwife present, either a band seven or band six. The lead midwife takes responsibility for organisation of the ward and allocates workload, ensuring she has an overview of what care is required and know which staff are providing that care. They are the main point of contact for all staff providing postnatal care. There is typically a band three maternity support worker present

who staff continue to refer to as an ‘infant feeding’ team member, as opposed to their official job title of ‘senior postnatal support worker’. Having a band three support worker present throughout a shift gives their colleagues a feeling that the BFI principles are protected and that the key messages of it are being delivered, they are deemed as having the most up to date evidence-based knowledge. Joan’s feelings about the BFI and the band three team is, “it’s their bread and butter”, however this is not the case due to a lack of consistent, regular BFI education.

To become a postnatal lead midwife, there is a selection and interview process. During a night shift there is no ‘official’ lead midwife working on the postnatal ward, occasionally there is a band three support worker working from 20:00 until either 22:00 hrs or midnight and so the protected feeling throughout the day is not always present at night. Staffing numbers allocated to the night shift are also an important factor. There are routinely less staff present at night due to the reduction in elective workload, regular health examinations and medical reviews will have been completed during the day. Elaine discusses that there is a feeling of disconnect between staff who work day shifts and those who solely work night shift, with this staff group being viewed as having their own culture and differing dynamics. Night staff are seen to be continuing to use outdated practices and work “in a certain way” which is felt to have become their ‘custom and practice’. This custom and practice was described as night staff being ‘fully aware’ of feeding support they should be providing but that bad habits creep in which is not protecting the BFI messaging:

> “The dynamics of the team overnight and the skills not necessarily being there let the bad habits creep in. Night core have got used to working in a certain way and it’s their custom and practice” (Joan)

It is not purely night shift maternity staff who are felt to be working as custom and practice, it is present within the SCBU, concerningly Jules alludes to Joans suggestion of staff working off piste:

> "People work on their knowledge, skill and expertise but that experience isn't always based on anything logical or scientific or researched…it's often done on what they've done in the past or what they've seen other people do that has worked…that's not evidence based" (Jules)

Joans feeling of bad habits is felt by other staff. Many maternity staff participants spoke of shift handover from night to day staff where a breastfed baby had been fed a bottle of formula milk to allow the parents to get some sleep overnight. There were also specific incidents highlighted of band two support workers routinely providing breastfeeding mothers with bottles of formula milk, it is unknown whether this is due to a lack of interest in the women's feeding choice or a personal discomfort in feeding support. Julia reiterates knowing that babies of who mothers wish to breastfeed are provided with formula milk throughout a night shift, she is quite often present to work an early shift and receives a handover from the night staff where it is affirmed that babies are given formula, night staff often say "we just gave the baby a bottle" (Julia). This highlights that the practices within this trust are mirroring those highlighted by Semenic et al (2012), some six years earlier than this study, where maternity staff were demonstrating inappropriate use of formula with a lack of sanctions from managerial staff when this occurs. Midwives have encountered some support workers overnight who feel that they are putting pressure on women by offering feeding support, the view being that by offering this support they are making mothers feel like they 'have to' breastfeed. Wren felt that there is a perception amongst the band two support workers that midwives are forcing mothers to breastfeed against their wishes, this was also discussed by Jules where SCBU staff have this perception also:

> "There is a real perception that we're pushing breastfeeding and I think that's a massive barrier…this idea that we're at fault for trying to promote something that's healthy" (Wren)

Night time was viewed as a critical time where mothers need good support from staff as they are likely to be tired and feeling vulnerable as a new parent and for those who struggle may change to formula milk. It is for this reason that midwifery participants feel it would be beneficial to have a band three support worker available throughout the whole night shift.

From the perspective of one night shift participant, she felt that breastfeeding support knowledge and skills are utilised much more during a night shift due to the absence of a band three support worker. There was acknowledgement, however, that there are times when they are too busy to provide support, which impacts the women and the skills of maternity staff:

> "When it is busy you don't have the time to spend with them [women] giving that extra bit of support. I think that's a real shame because it doesn't benefit us with keeping our skills up" (Perry)

Night shift participants spoke of a feeling of camaraderie and more partnership working at night although some admit they are unaware of how a day shift 'operates' or how staff interact with each other. They feel that they are very much a team where every staff member present is involved with feeding support even when their staffing numbers are reduced.

When midwives are in situations where a woman is requiring feeding support and they either do not have the time available or feel that they personally do not have the knowledge or skills, the band three support workers are usually referred to. There is no official referral pathway, they are approached by the midwife and asked to assist. Some midwife participants admitted that they had been in situations of providing feeding support and felt that they did not know what to do and had reached the limit of their skills, this resulted in them feeling uncomfortable as they want to be able to assist the women in their care. In these situations, this is when they access their colleagues for assistance however this is occasionally met with frustration. Ann questioned why band three staff are viewed as being able to do something different than midwives when providing breastfeeding support. Midwifery participants discussed that band three support workers are 'the experts' in supporting infant feeding and presume that as a team they have had more BFI training and so they have confidence in the band three abilities where they feel they have failed:

> "You know a couple of comments from the midwives are…I've been in there, can you go and put that baby on the breast because I've been in there half an hour and it won't go on…erm…what are you expecting me to do differently to you?...and I'll wait for the answer" (Ann)

The view from Ann above is a result of her experience of working within the maternity unit. There are members of the maternity team who are not confident with supporting infant feeding and therefore Ann feels that they rely very heavily on support workers. There is concern that when there are no band three support workers present, women and babies may not receive adequate breastfeeding care or evidence based information and may be supplemented with formula milk. This was found to be a practice of maternity staff by Semenic et al in their 2012 study.

In the absence of postnatal support workers, Rose stated that midwives are 'just getting on with it' [feeding support]. UNICEF UK website has many resources online for staff and families, these are accessed by postnatal staff on work iPads or laptops and are taken to families to view. A handful of participants refer to the website during infant feeding discussions although not all maternity staff are aware of the website, Rose is 'spreading the word':

> "I was talking with a colleague and I said 'oh do you know there is a hand expressing video'…you know, they didn't know so we are just trying to gently spread the word a little bit more" (Rose)

8.4.3 BFI training and knowledge

It was discussed by Julia that her opinion is that BFI training should be NHS trust wide, for all members of hospital staff, not solely maternity staff. At the time of the interviews for this study there were no current infant feeding policies available for any hospital staff to access. Robust policies and guidelines are beneficial for staff and those in their care as they negate personal opinions from encroaching on how care should be and/or is actually provided:

> "I think it does show if you don't have those robust policies and procedures in place then people's bias steps in and their personal opinions step in and we're on a bit of a free fall in not providing good support really" (Ann)

Participants do not feel up to date with the BFI, some admitted that they do not have a vast amount of current knowledge, a lack of education and knowledge has led to band two support workers refusing to provide feeding support when asked by midwives, stating 'it's [feeding support] not for them'. Amongst those who have limited BFI knowledge are senior midwifery staff, both clinical and

managerial. In their senior roles they are responsible for providing BFI training and other infant feeding support practices, such as safe demonstrations of preparing a formula feed to all maternity staff. Maternity support workers have approached their direct line managers to highlight lack of education and training opportunities, it is only then that training sessions are arranged:

> "Staff approach me and say we haven't had a catch up, so sessions are arranged…I don't tend to get involved if they're wanting more specific training" (Rose)

There is a managerial responsibility to provide regular training to ensure an equitable level of knowledge amongst staff. Midwives feel like they are failing women due to having little to no BFI knowledge. Many of the study participants, midwives and support workers alike, were unaware of the updated BFI standards since 2012 (UNICEF UK 2017), some were discussing the older, original standards and discussed the 'ten step' guidance. The following quote from Abby is interesting as there is judgement of her colleagues regarding their knowledge of the BFI standards whilst being outdated herself:

> "I think a lot of people don't really know what the standards are if I'm honest, I think we've all heard of the ten steps but I think if you asked somebody, they'd find it quite difficult to tell you what those standards are". (Abby)

There was not a consistent level of understanding of the BFI amongst participants, subsequently there is a variable level of support provided to women and babies. Some midwives felt that the BFI is an 'ideal' rather than the norm and that its focus is on breastfeeding at the 'expense' of other feeding methods. There was a general feeling among all participants that within this maternity unit there is a culture of not understanding that infant feeding knowledge is important, knowledge must be utilised regularly for staff to feel confident. When confidence was lacking, anecdotal information was used and given to mothers leading to them feel they were receiving conflicting advice. There are midwifery and support worker participants who ensure they continue to be updated with current BFI knowledge, when they attempt to inform their colleagues of the evidence, it is not always accepted as Lisa discusses here:

> "Sometimes we are seen as being the 'breastfeeding Nazis'…which we desperately try not to be like that, the women feel that as well…and it's…'no, the evidence in the research actually tells us this so strongly' and that's why we are saying what we are".

Lisa finds it frustrating that there is a lack of BFI knowledge of maternity staff, she felt that infant feeding support was often based in the "here and now" rather than staff realising that the impact of their actions, such as recommending formula supplements to breastfed babies or telling mothers that 'the baby just needs to be fed' regardless of method, will have:

> "The culture of 'oh yeah bottle feeding is fine' is still very much there and you're constantly fighting with 'at the end of the day your baby just needs to be fed'. There's an awful lot of that"

Daisy has a personal interest in the BFI and has accessed all the published literature to increase her knowledge and understanding, mostly due to the lack of workplace training. A handful of participants discussed that the BFI is an important subject within the maternity setting as the evidence that supports it underpins information mothers are receiving, however it was overlooked as an important agenda by some senior midwives. Vicky stated that she was not convinced the BFI makes a difference to women, her opinion was that the guidance was "not useful with unclear messaging". Vicky's personal opinion may have been tangible within the maternity unit as her colleagues discussed that there was no obvious support for the BFI in the ward environment, "there's no obvious support, no obvious breastfeeding policy anywhere, formula is just readily available" (Julia). One area of the BFI that was discussed by Vicky was the 'hands off' approach to breastfeeding support, this approach is when staff provide feeding support without touching the baby or the breast, she was honest about her cynicism:

> "The guidance just wasn't useful…'oh you mustn't touch the breast'. It was quite tricky because sometimes you felt like you just wanted to get the baby on the boob. As a midwife on the ward floor, I'm a bit cynical but I'm really happy to be convinced that I'm wrong" (Vicky)

The 'hands off' approach was also spoken about by Daisy. It is known throughout this maternity unit that there are staff who practice in this way,

despite the published evidence against the approach. Daisy, however, has felt an underlying pressure at times to work against this guidance, either because a woman has requested her to, or she had followed a colleagues' instruction. This placed her in a difficult position as her knowledge and practice were now conflicting, she felt unable to decline the requests being made of her as she is a lower pay band to her colleague:

> "Most [staff] are pretty hands off but then I was very aware that some weren't…there's quite a lot of pressure to practice in a hands-on way. I know there are times when I have done it, usually because I have been asked to by the woman or I've been told to by a colleague" (Daisy)

Wren recognised that the practical application of the BFI is reliant on many factors such as staff interpretation of the standards, which should be tailored to provide personalised care. There is the possibility of defensive practice from staff if their knowledge level is low, staff could worry unnecessarily about breastfeeding which may lead to an over intervention and being quick to step in to care and 'interfere' with normal processes. Practicing in a hands-on manner, at the request of the woman, may have been defensive midwifery practice. Defensive action is a result of the caring nature of maternity staff but also worry of a poor outcome for the baby which senior staff will become aware of, Wren felt this is a threat for staff:

> "We can be too quick to step in…it comes from a good place but I think it's a worry that there'll be a poor outcome and then management will pick up on it for us not having acted so there is an overarching threat of justifying non-intervention" (Wren)

8.4.4 Integrated care model and impact on knowledge

A large majority of midwives at this maternity unit work within an integrated care model, meaning that they have skills in antenatal, intrapartum and postnatal care, they work both within the hospital and the community area. There are occasions where midwives work in only one area, which can be problematic as it can result in long periods of time before they encounter particular care episodes. Senior midwives work clinically however there can be lengthy gaps between these shifts and as such there can be a degrading of their knowledge or that over time they have simply forgotten the BFI principles:

> "It may be quite a while before you see something, you may not have seen it for a while, months…years even, so there's elements of degrading of your own knowledge and experience if you don't use it all the time…it's not that you're not pro BFI, it's just that you've forgotten" (Joan)

Participants working within the integrated model felt that they need to have 'general' knowledge in all clinical areas rather than having in depth understanding. It was noted that there are midwives and support workers who have a preferred area in which to work, this is encouraged by the ward co-ordinators. Perry feels that every midwife has a clinical area where they feel their strengths lie and that for some, providing infant feeding support is not that area:

> "Everybody's different, every midwife has got her strengths and areas they like to be in, for some you know, breastfeeding isn't where they want to be. They want to be delivering babies, spending time with women in labour, others really enjoy the postnatal aspect…that's where their passion is" (Perry).

Current literature suggests that there is a process of deviation from midwifery models of care when working in integrated maternity practice owing to an increasing medicalisation of maternity care however further research is required to explore where conflicting pressure may like between midwifery care and a dominant medical culture (McFarland et al. 2020).

8.4.5 Preparation for UNICEF UK re-assessment visit

In preparation for the UNICEF UK re-assessment visit there was an attempt made to update maternity staff knowledge, this occurred over a short period of time at the beginning of 2018. Preparing staff for this was the responsibility of senior midwifery staff who enlisted other staff, of varying bands, to approach their colleagues and disseminate current BFI information. At this point it was felt by Tania that most maternity staff were not interested in developing their infant feeding knowledge:

> "too many midwives who were not working within the guidance provided by the BFI and were not interested in improving their care, although some staff were brilliant" (Tania).

Staff who were involved in disseminating BFI knowledge within the unit offered for their colleagues to shadow them in practice with the intention of increasing

confidence in the BFI principles. They were also present within the maternity unit to be available to discuss any theoretical elements of the BFI with their colleagues. There were ward based midwives who were self-motivated to talk to peers about the BFI and highlighted to their colleagues where an increase in knowledge and support for staff was required. The process of educating staff was not allocated enough time:

> "It was felt that the preparatory time wasn't long enough, it was all a bit of a rush job with a long preamble and the final hard work being quick in the end" (Daisy)

Maternity staff who were not involved in preparing for the reaccreditation visit felt that the whole process was purely a tick box exercise, many participants spoke of being given a sheet of paper with questions that UNICEF UK would be asking, along with the answers, both questions and answers were to be rote learned. Staff were informed to 'read up' on the BFI to ensure that they were up to date, midwives were then advising each other on what to revise:

> "Midwives were saying 'make sure you know about the anatomy behind breastfeeding and that you're clued up about how many times to feed in 24 hours because if you get asked by somebody you're going to know the answer which basically ticks a box" (Jean)

Participants did not feel that it was meaningful to just 'read up' 24 hours before the UNICEF visit, especially if they viewed it as only a tick box exercise. Midwives felt that the process of learning the correct information was a test, which if they did not pass, became the sole responsibility of the individual. This was how they felt it was worded to them by senior midwifery staff resulting in the general consensus that no midwife wanted to be present on shift and asked to speak to the UNICEF UK assessors, there was an aura of examination conditions. Due to the lack of mandatory training and no regular, meaningful BFI updates, staff felt under pressure. Those who were selected to talk with UNICEF assessors felt responsible for the whole unit, those who were not present at the time say they had 'escaped':

> "The responsibility was on just a few individuals that were selected on the day…I managed to escape them all. You didn't want to be the one they asked because you felt like it was

> under exam conditions…if you got it wrong it was detrimental to the unit" (Perry)

Lisa reiterated that the last minute preparation felt like 'fighting' around to ensure staff 'knew what to say' to UNICEF, but highlights that the lack of training would clearly have an impact on the unit passing the required re-assessment outcomes. Those participants who attempted to increase maternity staff knowledge prior to the visit felt "devastated and embarrassed" (Daisy) at losing accreditation status, whereas Tania would have been upset if the unit had passed the assessment:

> "If we had passed, I would have been very upset as we weren't good enough. It would have been an indication that the BFI wasn't doing what it had to. I don't think we started on it [preparation] in good enough time to really do the iterative thing, we didn't get to that point".

8.4.6 Conclusion

8.4.6.1 Staff knowledge

Many participants have feeding knowledge due to their personal feeding experience, these experiences were not always positive, with support being a 'hands on' approach from midwives and then being left to learn further skills by themselves. This self-taught knowledge is, for some, the only knowledge they have, which is not evidence-based. Staff impart this knowledge onto the women in their care which occasionally leads to a feeling of receiving conflicting information, different stories and helpful 'tips' are given albeit against the managers instruction not to do so. Maternity staff may have personal baggage regarding their feeding experiences, they could have encountered challenges and difficulties which has the potential to impact their ability to provide support to mothers and babies.

8.4.6.2 Differing knowledge

There is a vast difference in knowledge amongst maternity staff who have only worked within this unit and those who have experience of working at other NHS trusts, between those who have trained at BFI accredited universities and those at unaccredited universities. Possibly, there is a small cohort of staff who have not had any BFI training at all, they will have qualified prior to the development of the BFI standards. This was recognised by participants, who felt that it may

prove difficult to approach this staff group to update them with current evidence as they were viewed as being ‘stuck in their ways’ or provide care in a way that ‘they have always done’.

Throughout a day shift there is a lead midwife present which gives an overall feeling for staff of a protection of BFI principles, there is no lead midwife present during a night shift. The views of some staff regarding the night core team is that they work to their own ‘custom and practice’ and allow ‘bad habits’ to inform their care giving. There have been examples of care during a night shift such as formula supplements being given to babies, or mothers being provided with full bottles of formula milk as staff do not want to ‘pressure’ mothers into breastfeeding. These practices are unlikely to benefit women especially when they may be tired and feeling vulnerable during the night shift hours. Staff who work as part of the night core team felt that they ‘have to’ utilise their feeding support skills more than their day shift counterparts, this is due to having less staff present in general and no support from a band three support worker for a full night shift. They acknowledged that due to less staff they are occasionally too busy to support mothers and babies which not only impacts care, but also affects their skill level and maintenance of their skills.

Midwives informally refer to band three maternity support workers to provide feeding support, however this was not always well received. The views of some support worker participants are that midwives should be providing the same care as them and it was questioned that if midwives find feeding support challenging, how will support be provided when no band threes are available. Midwives discussed that they ‘just get on with it’ and utilise online resources provided by UNICEF, although this is not universal or routine practice.

8.4.6.3 Training/knowledge

Participants felt that embedding the BFI principles should be NHS trust wide and not solely for the maternity department, up to date policies and guidelines should also be accessible for all staff. Most maternity staff who participated in this study felt out of date with limited knowledge, resulting in some staff members refusing to provide support. Senior staff who have responsibility for staff training also admitted to having limited BFI knowledge, they will arrange

training sessions for staff only when these groups request it from them. This lack of knowledge makes participants feel that they are letting women down. Managers have a responsibility to ensure an equitable level of knowledge amongst staff as currently there is no consistent level of understanding and a general feel of not understanding that infant feeding support is important.

Not all staff felt that the BFI makes a difference to women and babies in that it provides unclear messaging, the main reason given here was that they do not necessarily agree with a 'hands off' approach to feeding support. There have been circumstances where staff have recently practised in this way due to peer pressure to do so. Providing babies with formula milk as a supplement was explained as 'defensive practice' due to an over-arching threat from management of not intervening should a poor outcome occur.

8.4.6.4 Integrated model of care and impact on knowledge

Staff who work within an integrated care model work in all areas of the maternity unit including antenatal, intrapartum and postnatal wards. They have 'general' knowledge and skills in all areas. There is no agreement about whether this works well for staff, some feel that working in one of these areas alone as core staff members should be encouraged. Midwives have preferences of which aspect of care they would like to provide, and these strengths should be supported, although this can be problematic. If staff work in just one area, they may not encounter certain issues in other areas and so when they are faced with this, their knowledge may have waned or they have simply forgotten the BFI principles.

8.5 Time

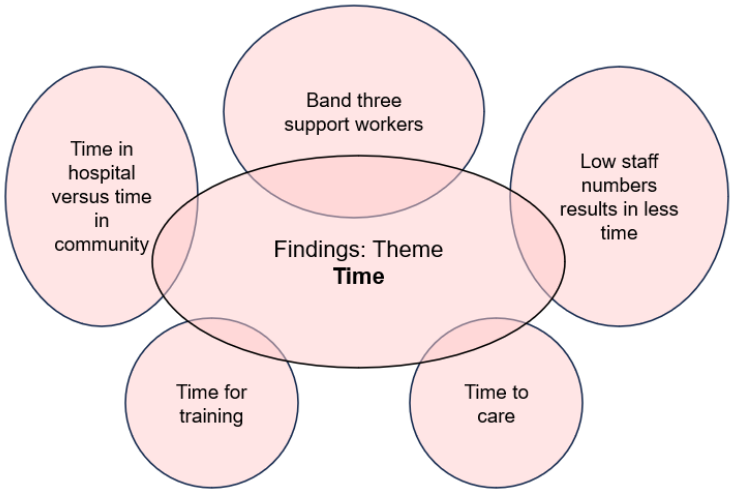

Figure 10 Findings theme: Time

This section of findings presents how 'Time' is a factor which impacts care provision. The following sub sections discuss the various factors as identified by participants. 1) Time for training discusses how training has reduced since the years 2000-2018 and the reasons for this, 2) Time to care identifies that maternity staff and those in their care wished to have time available for feeding support. 3) Time in hospital versus time in community discusses why staff felt that care and time in these two areas are different. 4) Low staffing numbers results in less time available for staff to provide care and 5) Band three support workers, this sub section highlights how this team of support workers was developed and why and how 'time' impacts on their care provision.

8.5.1 Time for training

Betty who began her employment with the trust within the preceding two years of this study has had a minimal amount of infant feeding training which she described as a 'quick video' which was incorporated into a two-hour teaching session. This session has been the only one available to her and both she, and in her opinion the trainer, would have 'liked' more time allocated for it. Betty felt that she would have welcomed more time for training, suggesting two days or a week duration as there had been occasions where she was required to provide infant feeding support without any professional education or knowledge as there were no trained staff available, either midwives or band three support workers to offer breastfeeding support at the time:

> "There was nobody there to give breastfeeding advice, the baby was sleepy but I helped, the baby latched…I walked out of there like 'I've done it, I've helped her" (Betty)

It was not only Betty who discussed lack of time allocated for BFI education and training. As discussed, BFI education was removed from mandatory training, midwifery managers no longer allocated time for maternity staff to attend. Tania was exasperated at the loss of time allocated to BFI training, in favour for other "priority" agendas:

> "The other things that were brought into training pushed breastfeeding out, absolutely absurdly because it's important and more relevant because everybody has to feed their baby…breast or formula" (Tania)

Time allocated for training was removed with lack of funding presented as the reason for no BFI education or updating opportunities for staff. In the absence of formal training there were some midwives who took proactive approaches to increase knowledge amongst their colleagues by discussing the BFI standards. Perry talks of one midwife in particular who took advantage of time that maternity staff had available between patient care in an attempt to engage them with the BFI principles, particularly prior to UNICEF accreditation visits:

> "She did a lot of one to one, half an hour in between you seeing women, she'd pull you to the side and say let's go through some questions" (Perry)

To staff this appeared as being ad hoc and resulted in an uneven knowledge base amongst midwives as not all staff members were approached.

Vicky suggested that when maternity staff do not feel skilled in providing infant feeding support, they use lack of time as an excuse but conversely recognises that lack of time is a true factor:

> "Staff don't have anywhere near enough time as they would like to give good care although there may be some who will say they haven't got time and possibly, actually they just don't feel as skilled as they were" (Vicky)

8.5.2 Time to care

Not having enough time to provide feeding care and support was discussed by all participants. A support worker participant discussed that women and their

families want maternity staff to have the time to sit with them, to provide information regarding feeding behaviours and listen to and respond to any questions and/or concerns. Midwife participants identified time constraints as a reason for lack of care and the inability to sit with women, suggesting that this was a result of less staff allocated to shifts and therefore their workload was too high to allow time dedicated for feeding support.

Within the hospital environment there was not always the opportunity to spend time with women to talk to them, listen to them and explore their feelings and goals. Abby stated that midwives do not have the time to listen 'properly' and then subsequently cannot assist the family with their specific needs:

> "Midwives will hear what the mum is saying and not actually what she really wants to say. I don't think it's that they don't want to help, they physically do not have time to help" (Abby).

Participants explained that it can be time consuming to be with a woman and assist with breastfeeding and some midwives spoke of finding it challenging to allocate 30 minutes to an hour in a room or bed bay, especially if the postnatal ward is full to capacity and staffed with only one midwife and one support worker, either a band two or band three. Time available for the women is reduced in this situation. In these situations, midwifery care can become task orientated rather than holistic as Penny discusses:

> "I know the benefits of breastfeeding but there are lots of challenges such as low staffing levels being difficult at night, support workers help if we're tied up doing drugs [supplying medication] or the clinical side of care running from room to room and trying to juggle everything…it's difficult to give breastfeeding support. A lot of it [barriers] is staffing and the amount of work that you've got to get through in the timeframe" (Penny)

Both midwives and support workers struggle with the lack of time to provide care. They want to be in a position to assist the women and families, however with an expectation of additional clinical roles for both staff groups, there becomes an extra need to prioritise workload which balances priorities by safety and clinical need, feeding support comes low on that list:

> "If you've got an understaffed ward and lots of ladies, with the best will in the world, feeding support is not going to happen. Sometimes you think 'well this baby is going to be feeding for an hour and I have a discharge home elsewhere to do'…you have to balance your priorities" (Abby)

This balancing of priorities then results in staff merely 'popping' in and out of rooms and providing a minimal feeding support service. Women are informed to use the internal buzzer system for assistance when required however maternity staff were feeling stressed for time and pressurised to complete their workload and to compensate, women were not being encouraged to use the buzzer:

> "We're all guilty of it, we just don't say to ring the buzzer as much because we know we'll be in there for a period of time that sadly we don't have" (Jean)

Most maternity staff felt a personal impact of these situations. There were often times where shifts ended and there was no chance for midwives or support workers to physically see all the women in their care or if they had answered a call buzzer, they would turn it off and leave the room, sometimes they were unable to return. This causes a high level of frustration as well as guilt. Rose regularly finishes her shifts and feels extremely guilty as she is fully aware of how important it is for women to feel cared for:

> "Quite often I will finish a shift and feel guilty that I didn't get chance…I said 'oh I'll be back in five minutes'…and I never went back. It's a horrible feeling" (Rose).

In these situations, staff feel as though they are not doing a good enough job. They work in maternity care to help families, they want to help with infant feeding support and it seems that only with good staffing levels and therefore time, can this be fulfilled.

8.5.3 Time perception in hospital versus time in community

When discussing how time and care is dedicated to families, Ollie spoke of the difference between working within the hospital and community:

> "On the ward it feels like a conveyor belt, at home it's a different feeling, you do give people a different kind of time" (Ollie)

This difference is felt by other participants. When providing care within a woman's home there is a perception of more time available due to having no other distractions in that environment. Time can be spent observing a full feed of the infant and adjustments of technique can be made if necessary, improving the feeding experience for the mother-baby dyad without staff feeling the need to rush away:

> "In the community most of the time we do have time to spend with women, you're just sat with her, and you can't just leave suddenly" (Lisa)

For Wren, providing feeding support within the ward environment can be frustrating, she is acutely aware of the ward activity such as buzzer alarms and telephones ringing, she then feels she begins to clock watch. As there are many other ward activities occurring simultaneously, Wren and other midwives wonder if their colleagues question what they are doing and why they are absent from the main ward. Self-inflicted time pressure is then applied. Lisa has heard staff ask others where colleagues are when they are in a room providing feeding support, in a way that suggests they need saving.

> "It's been said 'where's she been? She's been in there an hour doing breastfeeding support, god, god help her" (Lisa)

8.5.4 Less staff results in less time

Joan, who has a senior midwife position, acknowledges that lack of resources is real and not a construct of staff. Having good staffing numbers on a shift, with time to provide feeding support as well as completing clinical observations to meet current safety standards was described as a luxury. Resources such as low staff numbers were viewed as the main challenge as it results in a lack of time to care:

> "That's probably our biggest barrier and challenge at the minute, if you've only got one person on shift you don't have the luxury of time because you're spread so thin and that's the reality" (Joan)

Vicky, another senior staff member, reiterates this view that current maternity staff irrespective of pay band levels, do not have as much time available to be able to provide good care that they would like, but as previously discussed there

may be midwives who feel less confident in their skill set and state lack of time as an excuse.

8.5.5 Band three support workers

To mitigate for the lack of time and an increased workload for midwives, band three support workers were employed. As highlighted through analysis of the job description, experience and interest in infant feeding is required. At the inception of the postnatal band three support worker team, there was a general feeling that they were present purely to provide feeding support. They had protected time to listen to women, to understand their needs and provide good support. As with midwives, the band three team now have more responsibilities and extra clinical roles which was viewed by some members of the team differently. Daisy felt that the band three support worker role has become 'muddied' but did not necessarily mean to use that word with a negative connotation:

> "The role of the band threes has been muddied by…not muddied…that's a negative word but now there's so many responsibilities in the band three team" (Daisy)

Ann describes it as achieving a huge acquisition of clinical skills within the revised role but feeding support was no longer the focus of the team:

> "I'm grateful because I have a huge amount of skills under my belt but it has detracted away from what we do, I get it…it's really, really tricky" (Ann)

The clinical workload and 'tasks' of the postnatal ward are now their priority, which was welcomed by midwives, especially during a night shift. There is the general feeling amongst band two support worker and midwives that the band three team have more time available to spend with women, however Abby feels the same as Rose in that there were occasions where she gets home and reflects on how she was unable to return to a woman:

> "I often go home and think 'she really needed me to go back in' and I just physically could not do that. I took this job because I want to help but physically you can't see everybody as much as you'd like to and it's frustrating. Really frustrating" (Abby)

Midwives value the band three team and felt that there was a similar, if not the same, knowledge base regarding the BFI, when they [midwives] do not have time available to provide feeding support, they will refer to the support worker team. It has been questioned by some midwife participants that the reason a band three team was required at all was that midwives were not doing a good enough job themselves:

> "I value their role [band three's] but how it's happened it because midwives aren't doing a good enough job. Maybe I wasn't doing a good enough job because I don't have time to do everything…for the training, for the time to spend with women. Well to me that's not a midwife" (Ollie)

Whilst Ollie will refer to the band three team when she does not have the time for feeding support herself, Vicky has the opinion that midwives and band two support workers refer to them as they are viewed as an expert feeding team who perform at a high level. Midwifery management participants stated that when the team was developed and introduced it was made clear to all staff that they were not to be utilised as a midwife replacement for the feeding support role. It may be inevitable that when a midwife feels less skilled in that area then the band three support workers will be referred to.

8.5.6 Conclusion

8.5.6.1 Time for training

Many participants were employed within this maternity unit when mandatory training was present and supported by management, throughout time there has been a developing safety agenda whose items have taken priority over breastfeeding training which has left staff feeling disappointed. The provision of training was based around financial factors, and should money become available, staff were very keen to attend training, this will result in all maternity staff having an even knowledge level of the BFI.

8.5.6.2 Band three support workers

Midwifery management recognised a need for a support worker team who would have the knowledge and time to assist with providing infant feeding support and subsequently employed staff with experience and training in feeding principles. At the inception of the team their sole focus was infant

feeding support, they were accepted by midwives and are very valued as members of the maternity team. They were never to be a replacement for the midwife nor were midwives to relinquish their feeding support roles. Over time, this team, like midwives, have inherited extra roles and responsibilities which has changed the focus of their priorities, they must now perform clinical skills and tasks ahead of infant feeding support. They are now in a similar position to midwives and facing the same challenges of not having enough time to provide care, leading to a frustration within the whole band three team.

8.6 Responsibility for providing infant feeding support

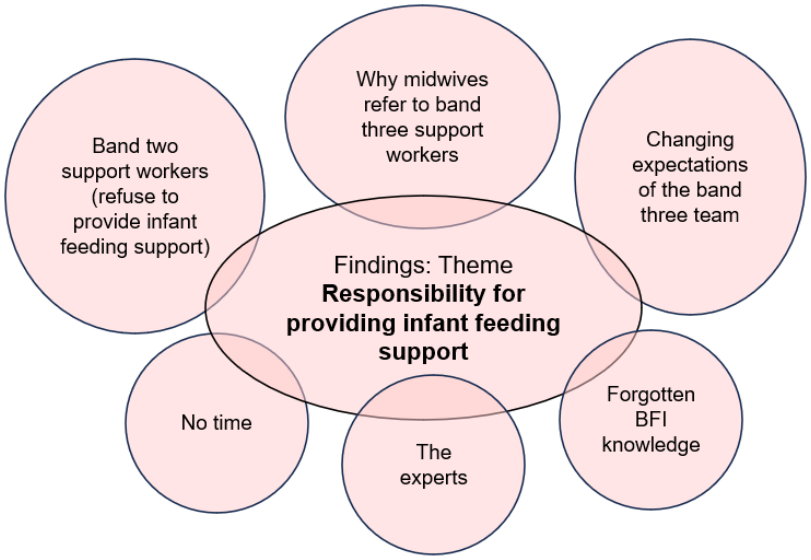

Figure 11 Findings theme: Responsibility for providing infant feeding support

8.6.1 Introduction

As previous findings have demonstrated, there is no consistent regular BFI education and training for staff of any pay banding, so when either a band two support worker or midwife feels that they have reached the level of their professional expertise, they refer to colleagues who are deemed as the experts in infant feeding support, in this maternity unit those experts are the band three support workers. The official title for this group of support workers was unclear amongst maternity staff participants, as highlighted by the differing job role descriptions from the document analysis. Participants talk about the team using interchanging titles including the ‘infant feeding team’ and the ‘band threes’.

The following findings will demonstrate that a handful of band two maternity support workers will refuse to provide infant feeding support to women for various reasons such as; they believed it was not in their job description, they do not get paid to do it, they do not support breastfeeding and they have had no training. Some of their colleagues feel they are merely lazy and uninterested in supporting families and therefore it is 'easier' to not ask them to assist. As analysed in Section 7.3 the job description of a band two support worker will be discussed in relation to these findings.

Why midwives refer to the band three support worker team will then be discussed, whilst midwifery management participants have sympathy for the band two team when they are referred to, midwives are also believed to have their own reasons for not providing feeding support themselves. Lack of time/having no time due to a busy and often complex workload or low level of staffing numbers was often cited as the main reason for not providing feeding support. Midwife participants have admitted that they can forget their BFI knowledge, the reasons for this and how they manage it is highlighted. The band three team as experts, what their colleagues expect them to provide and their feelings toward referral to them is discussed, including their many different and interchangeable job titles.

Finally, there is discussion as to why, when and how the role and expectations of the band three support worker team changed including their own thoughts, thoughts of the midwifery staff about the change and managerial response to disgruntled staff. Their job description from Section 7.4 is revisited here.

8.6.2 Band two support workers

Betty discussed that her band two colleagues do not perform extra clinical roles like band three support worker team, she was aware that there are some who are not keen to help with infant feeding support and have been heard saying that it was not in their job description or a requirement of their pay band and will say this to midwives who may ask for their assistance:

> "Some say 'it's not in their job description' or will say 'no, that's not my band' when asked to go and help a family by a midwife" (Betty)

The job description for the band two support workers is regularly updated with the most recent being reviewed in 2022, towards the end of data collection for this study. The purpose of the band two support workers is to complete a wide range of tasks which support the maternity service including infant feeding care under the direction and supervision of registered midwives. The description of their responsibilities is clear, they are required to assist women with basic advice about feeding their babies, either to assist with breastfeeding or demonstrating the safe preparation of formula feeds. Within the person specification they must have a basic knowledge of UNICEF UK BFI and infant feeding principles. Supporting infant feeding is required alongside other expected duties.

Wren had first-hand experience with band two support workers who were not willing to help women with feeding support when asked: ""there's some that just say oh no I don't do breastfeeding support, no that's not for me". Whilst Daisy recognised the opposite: "some of the band two support workers are epically brilliant at it" [breastfeeding support].

Band two support workers are present on all ranges of shift patterns and are often the only support workers on a night shift. There has been a variance in skills and personalities of this group noted by midwives, there are those who have been described as "absolutely incredible" (Perry) in providing support for women, especially to those who are requiring additional support with feeding their baby but there are those who do not have an interest in infant feeding: "there are a couple I know [band two support workers] that aren't keen" (Betty) and refuse to help due to not being paid the same salary as a band three support worker. This feeling of animosity from the band twos is felt by the midwives they work with:

> "It is very apparent on a night shift, it's very sad that we live in a culture that it's dependent on pay scales as to the workload you're going to do" (Perry)

Midwives have made the decision to not ask these staff members to help provide feeding support due to receiving a negative response from them and it

was felt to be easier to try and do the job themselves as it was “less hassle” (Perry).

As with other maternity staff, band two support workers do not have any infant feeding education or training, this may result in a lack of confidence for supporting women. In the absence of training and in a bid to increase their confidence, some support workers have asked their colleagues if they can observe support being given or talk through scenarios so that they can learn from them, but this does vary amongst this staff group. The skills amongst support workers varies, from those who are able, to those who have “little willingness to participate in feeding support” (Wren). Unfortunately, when a band two informs midwives that they have not had any training, this is met with suspicion of it being an excuse to shy away from feeding support. Not all, but some of the band two support workers are recognised as being lazy and having no interest in helping with feeding support or in doing much else within their role:

> “There’s a few that make excuses up, some are not interested in helping with feeding, some don’t want to be involved and some are, erm put this politely…lazy, not keen to do much else. Some never have done it so they’re not going to start doing it now” (Rose)

Those who are unwilling or not confident in providing feeding support will be more inclined to refer to a band three support worker.

8.6.3 Why midwives refer to band three support workers

Some midwife participants feel sympathy for the band two support workers and the expectations of other staff for them to provide feeding support as it is likely that they will have seen midwives waiting for a band three to be present to give feeding support or that the expectations of them are unrealistic.

> “I have real sympathy for the band twos, I think the expectations of them needs to be very realistic and very clear if they are expected to provide the same level of breastfeeding support when possibly they are seeing midwives waiting for an infant feeding support worker” (Vicky)

The reasons provided by midwives in this study as to why they refer to the band threes were that they did not have enough time to provide infant feeding support

themselves, that they have forgotten the knowledge or that the band threes are viewed as experts in the subject. These three reasons will be discussed below.

8.6.4 No time

Midwives in this study discussed how they are 'really busy' and that on these occasions, having the option of referring to a band three to give feeding support to a woman gives them a sense of workload relief. Vicky and Ollie have similar thoughts, with Vicky believing that a vast majority of midwives feel this relief:

> "I would say a vast majority of midwives, including me, tend to think 'thank God, there's an infant feeding person'" (Vicky)

> "It's like we can almost think 'thank the Lord, I can offload that'" (Ollie)

Participant Julia thinks that the band three team provide a good service to women but that often, midwives can be too busy to give support and so they refer to them which can result in an over reliance on the team. Julia talked about midwives being "too busy" and Vicky discussed how midwives "will say they have not got the time" to help with feeding support, these were said in an almost accusing manner suggesting that lack of time is being used as an excuse by staff to not provide feeding support. The feeling of over reliance on the band three support workers is reiterated by Lisa who recognises that the team are useful to have however they can be 'dumped' on:

> "The band two's…I don't think they do any feeding support at all… it's very much dumped on the band threes" (Lisa)

Participant Ollie spoke of there being a feeling of offloading infant feeding support onto the band three team, she does not always like referring, she feels that it is a position that midwives have been pushed into with an increasing workload and not having enough time to support women.

The presence of the band threes as a feeding support team has given Ollie a feeling that her role as a midwife is becoming fragmented. Rather than fragmenting the role by employing more support workers she felt that more midwives are needed. What was disappointing to hear is that Ollie no longer knows what her role as a midwife is. The word midwife has an old English definition meaning (to be) 'with woman' (Borrelli 2014) and this is how Ollie feels

when talking about her role. As a midwife, Ollie wants to be providing continuity of care for women when supporting them to breastfeed and promote bonding with their baby, she now has mixed feelings regarding the benefit of the band three team and felt that midwives now do not give the same level of breastfeeding support as it can be easy to refer to the band threes:

> "We need more midwives, not fragment the role. I think that (having band threes) diminishes the role of the midwife. I don't even know what my role is because it doesn't feel like a midwife anymore, we don't give the same feeding support and so I have mixed feelings (about the band three role)" (Ollie)

Ollie believes that her midwife role is eroding, with the band three support workers encroaching into what she perceives as her territory.

8.6.5 Forgotten UNICEF UK BFI knowledge

Whilst there appears to be recognition by participants that colleagues have had no BFI training at all or lack confidence to provide support even following training, it has been highlighted that maternity staff can forget what they have been taught. Midwifery management stated that it was never the intention for the band three team to replace midwives with supporting infant feeding, the original expectation of them was to focus on infant feeding support as a specialist team. Feeding support is not specifically highlighted as an important duty and they are not identified as a specialist team. However, when such a team exists and when staff forget their UNICEF BFI knowledge, as 'the experts', they will be asked to assist:

> "Sometimes you have forgotten some knowledge and you'll go to the local expert…expert by experience, expert by knowledge base, expert by skill set…so that's the infant feeding team, and say 'oh this baby in this room is doing this…what should I be doing?'" (Joan)

8.6.6 The experts

Midwifery managers assume that all maternity staff will naturally refer to a band three support worker as they are viewed as the experts by experience, knowledge base and skill set and that it is 'normal' to seek expertise.

Whilst there was recognition by midwifery managers that it is normal behaviour to seek expertise in any area where staff feel their skills are lacking, the feeling

of midwives being able to 'offload' feeding support onto the band three team or over relying on the team does not go unnoticed by them. The feeling amongst the band three team was that regardless of maternity staffs pay banding, they should all be skilled and able to provide infant feeding support. There are practical skills such as formula preparation demonstrations that could be a routine part of ward care for all staff but in reality, every aspect of infant feeding care and information giving is 'left' to the band three team. From Betty's perspective, waiting for a band three member to either arrive on the shift, or to become available to refer to, for them to provide support was viewed as a positive for the women and babies. Colleagues of the band three team believe them to be an asset to the maternity unit and that women and babies get much more feeding support due to their presence:

> "You've got the [band 3's] now so I think the ladies (postnatal women) get more support because of them, they literally come on shift and we give them 'that lady needs breastfeeding support'…I think they're doing a fab job, they are definitely an asset" (Betty)

There was recognition by participants that colleagues were waiting for the band three team to arrive on the postnatal ward. Midwife participants felt that there was an over reliance on the team and discussed how their colleagues have actively waited for their arrival, with a long list of tasks, suggesting an avoidance of feeding support themselves. Lisa suggested that if staff have time to write a list and wait, feeding support could have been provided:

> "Midwives wait for them to turn up and give them [(band threes) a list of lots of things to do, some midwives aren't doing what they should be doing, rightly or wrongly…you shouldn't avoid doing the support yourself because there is a band three around" (Lisa)

Ollie and Julia both felt that infant feeding support is an essential part of a midwife's role, they want to be with women providing continuity of care and this can be completed as part of the postnatal care package for the woman and baby.

Women who use this maternity service are aware of the 'infant feeding team', which is viewed as a positive for this trust as it is not a service that is available

at all NHS trusts. Whilst it has been highlighted that staff will actively wait to refer to a band three, there are women who ask for them to assist instead of a midwife. Ollie has become despondent when asked by women if a band three is present, she feels that women already have an idea that the team are more knowledgeable and then does not explain that she can give the same support:

> "The women might say…'is one of the infant feeding team there to help with feeding'…I can do it you know but sometimes I don't even wanna argue and say I can do it" (Ollie)

Whether it is a band two referring to them due to having no confidence, no knowledge or are generally disinterested, or if it is a midwife referring due to having no time, they have forgotten what they should do or that a woman has asked for them, the reason for referral should be made clear. The quote below demonstrates how it felt to this band three support worker when colleagues wait for her arrival:

> "I almost feel like a walking boob sometimes walking in… (colleagues say) 'thank god you're here'…I'm not going to do anything different…I'm a walking tit, I've actually used, I feel like a walking tit when I walk in" (Ann)

Not only was there confusion as to why staff refer to the band threes, there was confusion about their title and the expectations of their role. There were many different titles used interchangeably throughout the interviews. These were 'infant feeding team', 'senior postnatal support workers', 'senior maternity support workers' and the 'band threes'. Midwifery management stated that the title 'infant feeding team' was chosen by the band threes themselves but admitted that they "honestly do not remember" (Vicky) how that title was decided and agreed. Ollie thinks that the inception of the band three team owed to the fact that midwives were not doing a good enough job of supporting women with infant feeding. The role initially stemmed from a need to have staff with protected time to support women and babies with breastfeeding and this time was very much protected. From the support workers perspective, they only expected to give breastfeeding support as it was the focus of their role within the maternity ward.

8.6.7 Changing expectations of the band three team

Over time, role expectations began to change as midwifery managers became aware of the roles of band three support workers at neighbouring NHS trusts, for example working in the community setting as support to the midwifery team. This was common in neighbouring trusts and aligns with the Royal College of Midwives (RCM) (Royal College of Midwives 2023) definition of a band three maternity support worker who may work in a variety of settings, including care in the woman's home in the absence of a midwife. Although their role at this trust was initially focussed on infant feeding support, they were also expected to complete extra tasks within their role. With these extra tasks came a higher level of responsibility and a detraction from infant feeding, the band threes stated their role had changed massively and they feel pulled in many directions and whilst they recognise the extra tasks are important, they have resulted in the loss of protected infant feeding support time. Ann felt that the protected time was not always a benefit:

> "It's a double-edged sword because if you have that protected time then other staff feel they don't have to do it (feeding support)" (Ann)

Being required to complete extra tasks was viewed as a double-edged sword. Although they have detracted from the protected time and the ability to exclusively provide feeding support, the result was the band threes have become more highly skilled, which some of them are grateful for. Daisy discussed that there have been staff joining the band three team who are less experienced than others, who have received less training and appear to have less interest in infant feeding, when these new staff members show an interest in developing their skills, this was viewed as them purely wanting to develop their career:

> "We've had people in and out of the team who have a lot less interest in breastfeeding, they're here…they're interested in maybe climbing up the banding, working in the band three team and doing all the other skills now that feeding has become less and less of an important criteria for them…we didn't do anything else" (Daisy)

Section 7.3 discussed the job descriptions for the band three support worker role. At the time of Daisy's interview, the key areas of responsibilities for the team included the provision of many aspects of postnatal care including the removal of urinary catheters, removal of intravenous cannulas and obtaining vital sign observations alongside providing detailed infant feeding advice. There is an expectation that all band three support workers complete these clinical skills as part of their role and as such cannot be seen, as Daisy suggests, just an interest in climbing up the banding ladder, with infant feeding becoming less important to them. The most recent job description that was analysed was reviewed by midwifery managers in 2020 and incorporates the skills above, the only addition to the band three role being a requirement to contribute to the provision of antenatal education. At the time this study was being completed, there were COVID-19 restrictions in place, one of these was the cessation of antenatal education classes, women and families no longer received face to face information. Regardless of who is responsible for its provision, Jean was very passionate about it, she felt that providing antenatal classes and education would assist with increasing the understanding of women regarding breastfeeding but acknowledged that time would be needed to sit and explain the anatomy and physiology to them although she felt that this would be of benefit in the long term:

> "I think once they've got a new baby postnatally they're probably quite drained and tired, it's all a new dynamic, they don't have the time to be able to digest a lot of what we say. We need to bring back antenatal classes, being surrounded by other women who are like minded and they have time to think about what they have been told and can research more" (Jean)

From a managerial perspective, investing in support workers by increasing their skill set and equipping them to be the best practitioners they can, will add value to the maternity system of care, which will ultimately benefit the women and babies. This view was not shared by all. Ollie believes that the band three team has developed as a money saving agenda due to midwives' workload being high, this aligns with Ann who feels that the band three team are used as

cheap labour. Her view is that the team are cheap midwives, with the only care they cannot provide is facilitating the birth of a baby, provide antenatal care and dispense medications:

> "We're cheap, let's face it, the only thing we can't do is catch a baby, do antenatal care and give drugs out…if I'm putting it bluntly, we're cheap, we're cheap midwives aren't we…if you can get away with a band three to do it rather than pay a band six to do it then why wouldn't you?" (Ann)

When Vicky was directly asked what she thought about the above quote and Ann's feelings, she replied saying that it was true. Vicky and Joan are classed as senior staff within this trust and were both asked how they felt to hear that the band three team felt like they are viewed as cheap midwives. There was a feeling of disappointment and sadness, with Joan suggesting that the team possibly felt this way due to dissatisfaction with their salary in relation to the expected level of responsibility. Although Joan felt sad, it was mostly disappointment at the negative view:

> "I feel disappointed because that's quite…I don't want to say inflammatory but it's quite a negative thing to say so I just wonder if it's wrapped around their pay grade" (Joan)

Hutchinson (2014) discusses how a London based hospital have developed a comprehensive induction and training programme for maternity support workers alongside the appointment of advanced support workers. These support workers are employed as band four and have responsibility for providing in depth breastfeeding support. The definition provided by the RCM for a band four maternity support worker is that in addition to the expected roles of the band three they will have additional responsibilities with increased organisation and communication skills (Royal College of Midwives 2023). The roles of band four support workers as described by Hutchinson (2014) are the role expectations of the band three team at this trust.

Vicky suggested that Ann's view demonstrated a lack of satisfaction with her job and a lack of ambition, she agreed that the role of a band three support worker had increased but that other roles within maternity have developed in that way. The role of the midwife has changed in response to a reduction in the

contracted hours for junior doctors as set out in the EWTD (Hutchinson 2014) with midwives now having more responsibilities and a requirement to expand their skill set due to the increasing complexities seen in maternity care. These extra skills that midwives are now expected to complete has impacted on their workload and time available to provide care and in response, midwifery managers are utilising the maternity support workers. There was an expectation that those who apply for a band three role demonstrated that they have a passion for infant feeding and that if they did not, they should not apply. The band three role then developed in response to other hospital trusts having band three teams who provided more than solely infant feeding support. The view by some band threes that they are being used as cheap midwives, from Vicky's perspective, suggests that it is not the right job for them and that it can be a self-destructive opinion for which she is not sympathetic:

> "If that's your approach to a role then it's probably not the right job, if people feel like that then it's not the right role for them…that would be as self-destructive as a midwife saying I'm really fed up with the fact I'm now supposed to do episiotomies and suture them cause that's a doctor's role. Midwives are paid more as they have a higher level of responsibility so I'll be honest, I wouldn't have a lot of sympathy" (Vicky)

The title of 'infant feeding team' suggests a higher level of knowledge, an expertise in infant feeding. As Ollie discussed there are women who ask for the band three team to assist them instead of a midwife as they may feel that they are more knowledgeable. With some support workers at this trust then that may be correct, four of the band three team had gained qualifications as breastfeeding educators, peer supporters and counsellors prior to becoming employed with the NHS, these courses were completed voluntarily. The rest of the band three team members have joined the team with no prior training or knowledge and have no induction to the role or targeted infant feeding training, they shadow a band three colleague for. The length of time they shadow for varies depending on the confidence of the newly employed support worker. Ultimately, when a woman requests a band three support worker, it could result in an inexperienced and untrained person providing feeding support.

There was a sense of frustration within the band three team. There are midwives who will refer to them for many reasons, as suggested, and there are band two support workers who refer to them also, they were trapped between the two staff groups who state that it is their job to provide infant feeding support. The band three team state it is, or should be, the responsibility of all maternity staff to provide infant feeding support and that potential support workers should not be recruited if they will not support infant feeding.

8.7 Conclusion to chapter

Most midwives graduated from a BFI accredited university, gaining substantial initial BFI education and knowledge. However, workplace training has declined, with removal from mandatory training due to cost implications and perceptions of low value. This erosion of training produces ad hoc, variable infant feeding support practices. Maternity support workers have diverse training backgrounds, ranging from extensive external qualifications to minimal workplace training. Band two support workers are expected to provide basic feeding support, though some lack willingness. Band three support workers are viewed as experts yet many lack formal training. Band three support workers felt frustrated at being referred to constantly, they feel they are used as "cheap midwives" as their roles and responsibilities have expanded. Midwifery managers defend the role changes as expanding clinical skills.

Overall, the training picture is fragmented, with gaps for all staff groups. This threatens care and risks disengagement of staff. Key issues include transitional knowledge loss for newly qualified midwives, complex barriers to delivering training, variances between trusts and role confusion around support worker responsibilities. Stronger governance of education programmes is required to ensure staff remain updated in supporting evidence based infant feeding practices. There are clear implications for staff confidence and competence.

Many staff rely on personal infant feeding experiences as foundational knowledge, though this is not evidence-based. Knowledge levels vary considerably between universities, NHS trusts, staff bands and shifts. There are midwives with no workplace BFI training and training for support workers can be ad hoc and reactive, staff knowledge is fragmented and outdated. This

represents a key barrier to consistent, high-quality care and infant feeding support. Underlying issues include lack of training governance, variable education background, erosion of knowledge over time and presumed rather than proven expertise. A culture shift towards proactive knowledge curation is required, underpinned by robust training programs. A review of support workers responsibilities and training needs is required so that consistent, equitable support is provided to women.

8.8 Overview of research themes

An overview of research themes is found in table five below:

Table 5 Overview of research themes

Theme	Description	Link to Other Themes	Implications for Practice
Staff Training	Formal education provided to staff on evidence based infant feeding practices, policies, and guidance.	Enhances staff knowledge; Supports professionals' responsibility Requires time for allocation to attend training sessions.	Regular, structured education and training builds competence and confidence in providing consistent infant feeding support
Staff Knowledge	The understanding staff have about infant feeding and the UNICEF UK BFI standards	Knowledge can be dependent on the quality and frequency of staff training Informs their ability to assume responsibility for supporting breastfeeding	Greater knowledge leads to higher quality support for parents and better infant health outcomes.
Time	The amount of time staff have available to provide infant feeding support during their working day.	Lack of time can limit both attending training and the ability to fulfil infant feeding responsibilities effectively.	Adequate staffing and workload management are essential for sustained, high-quality infant feeding support.
Responsibility for providing infant feeding support	The extent to which staff are expected or required to provide infant feeding support.	Staff may be more willing to take on responsibility if they have the knowledge and training and time.	Clear role expectations and support systems help ensure consistent and accountable care.

Chapter 9 Discussion

The research findings are discussed in this chapter and highlight the experiences of maternity staff participants when implementing the BFI within the maternity unit. Barriers and facilitators are discussed including factors of staff training, staff knowledge, time and responsibility for infant feeding.

Chapter nine provides an analysis of the organisational, individual and socio-political factors that impact BFI implementation, structured around three key themes of lack of staff education, lack of resources and confusion over roles and responsibilities for infant feeding support. Moreover the significance of studying organisational barriers and facilitators to BFI implementation is highlighted, given the initiative's importance for maternal and infant health outcomes.

This chapter is organised into three factors which are both barriers and facilitators to the successful implementation of the BFI; 1) Organisational, 2) Individual; and 3) Socio-political factors.

Organisational factors which result in BFI implementation barriers include lack of (a) staff education; (b) resources; and (c) clarity as to who has responsibility for proving infant feeding support. Facilitators within this factor are having managerial support for the BFI resulting in support for staff training, access for staff to clear guidelines and job descriptions and passionate staff who are BFI advocates.

Individual barriers include personal and professional infant feeding experiences of staff, which are formed outside of the organisational setting but impact on their care provision and maternity staff having a lack of belief and/or a lack understanding of the BFI. Facilitators for this maternity unit are staff who have infant feeding support skills gained through training prior to employment with the trust and midwives and support workers who have belief in the BFI standards and evidence which supports them.

Socio-political barriers are maternity staff not adhering to ‘The Code’ (WHO 2018), lack of peer support networks within the unit and negative terminology and actions used between colleagues. Facilitators here are the presence of

voluntary peer support groups within the community and the presence of 'The Code' to enable education of staff.

Section 9.2 explores how the removal of BFI education and training for maternity staff is a major barrier to successfully implementing the BFI. The explanations and reasons why this decision was made is provided by midwifery management alongside a discussion on the impact of that decision for both staff and women. A facilitating factor for the unit was the recruitment of a BFI lead midwife in 2021 and the reinstatement of BFI education for all midwives, maternity support workers and neonatal staff. I was the BFI lead midwife that the trust recruited which resulted in the identified barrier being acted upon as a priority whilst data collection continued.

9.1 Organisational factors

There are three organisational barriers to successful implementation within this maternity unit. The first is the lack of staff education which has three sub-themes: 1) the UNICEF UK re-assessment visit; 2) impact on staff; and 3) impact on women and babies. The second organisational barrier to BFI implementation is a lack of resources, again with three sub-themes of: 1) staffing levels, 2) workload expectations; and 3) time, or better 'no time'. The third organisational barrier was a lack of understanding who was responsible for providing infant feeding support. The latter is discussed in relation to the following groups: 1) maternity support workers; 2) the experts; 3) midwives; and 4) midwifery managers and BFI lead staff. Facilitating factors shall be discussed incorporating changes that were implemented prior to completion of the study.

9.2 Lack of staff education

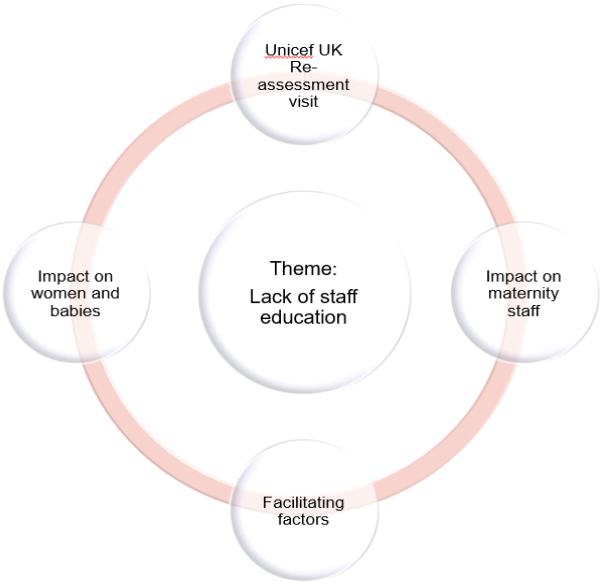

Figure 12 Organisational factor theme: Lack of staff education

Absence of BFI education was a significant barrier to successfully implementing the BFI standards. BFI principles and standards were removed by midwifery management from mandatory staff training in 2016, they were only reintroduced in 2021 following the appointment of a band seven BFI lead midwife. The reasons why education was removed shall be discussed. The impact that a lack of staff training and education has on both staff and those who they care for is discussed and how the re-introduction of BFI training for all maternity and neonatal unit staff, is a facilitating factor for implementing the BFI standards.

In 2014 this maternity unit was successfully re-accredited with UNICEF UK BFI, yet in 2016 the decision was made by management to remove the BFI from mandatory training, such as in person study days, online education packages and update sessions. Since 2007, when stage one accreditation was initially awarded at this NHS trust, two days per year were allocated for staff to attend mandatory BFI training. The BFI education programme was described by both maternity staff and management as “excellent”, when it was provided by an infant feeding lead midwife who had been active in leading the programme, however, following this midwife’s retirement, there was no replacement BFI lead midwife until 2021.

The lack of midwifery leadership in BFI education resulted in staff stating that the BFI study days between 2014 and 2016 were ineffective, with some staff commenting how their knowledge of the BFI standards had diminished. Midwifery management felt that the education provided during staff training was no longer meaningful and ultimately made the decision it from staff training completely. The main reason provided by a senior midwife participant was that it was too costly to train staff. Money for specific projects like BFI comes from NHS England (NHSE) through the local maternity and neonatal system (LMNS). The amount of funding and length that it is agreed for is a pre-determined period and links to national priorities reflected in documents such as the Three-Year Delivery plan for Maternity and Neonatal Services (NHS England 2023). In the absence of external funding, it became the responsibility of the Director of Midwifery, to justify such education in its annual business plan. Midwifery managers thought that the likelihood of the BFI being funded by the Trust was minimal due to more “pressing” priorities for an “ever-diminishing pot of funding”.

The contracts between the maternity service and the local CCG, dated 2014-2016 and 2020-2024 have the same wording regarding infant feeding. An intended outcome for the contract was for an increase in rates of breastfeeding initiation within the locality. One of the aims of the local CCG contract was to provide the best start in life for children, including increasing the prevalence and subsequent duration of breastfeeding, which has been highlighted as a necessity (Fallon et al. 2019). An element of the service model is to meet the requirements of the BFI standards (UNICEF UK 2017). There is no contract available for analysis dated 2016-2020 although there was a strategy document for the county published in 2014. This document was clear in stating that all maternity units within the county were required to be accredited to UNICEF UK BFI. It was recognised by the Integrated Care Board (ICB) that a local challenge was the provision of consistently high-quality breastfeeding support. A documented outcome in this strategy was for staff to become skilled in supporting breastfeeding. This outcome could not be met by the study site due to the lack of staff BFI education and training.

A second reason provided by midwifery management was a requirement to replace the BFI in mandatory training with other 'priorities', notably the safety agendas. Obstetric emergencies replaced infant feeding training and whilst staff needed to deliver infant feeding education understood that these are important skills to have, their opinion was that there is still a need for babies to be fed and for their parents to receive evidence-based care and, hence in their eyes removing BFI information from training was "absurd".

In consideration of replacing UNICEF UK BFI standards and providing local infant feeding education to staff, some midwifery managers in region began to investigate the feasibility of developing their own education programme accessing the readily available evidence that supported the UNICEF UK BFI standards to support their own education programme, however two participants at this study site were told by NHS England that they could not. The NHS Long Term Plan (2019) stated that maternity services must begin the accreditation process towards an evidence-based infant feeding programme '*such as'* the UNICEF BFI. No clear reason was provided to the participants as to why they could not form their own programme. I sent three emails to NHSE asking what is meant by '*such as',* no reply was received. It could be surmised that these two words made managers believe that other programmes would be acceptable. After being told they could not develop their own education package the decision was made to wait for a national steer and funding. As a result, until national money was provided no staff training would occur at this study hospital. Maternity staff at this study were very keen to attend infant feeding education and training when or if it becomes available. One reason provided by a manager with responsibility for the BFI as to why training and working towards accreditation was halted was funding not being authorised by the NHS trust accountant. A second reason provided by a different midwifery manager was that the NHS trust executive board were not informed of the BFI as it was not deemed a priority for the maternity services. These are opposing reasons. UNICEF UK BFI promote the development of a leadership team within NHS settings that identifies a high-level staff member, for example a senior manager or a member of the NHS trust board, to assume to role of Baby

Friendly Guardian. This Guardian becomes an advocate for the BFI at executive level.

As previously discussed, an online infant feeding resource was developed by a local university. It was licenced for surrounding NHS trusts to utilise for staff training, these trusts paid a nominal fee for access to the package for a set period of three years after which access would be restricted. Management proposed that all maternity staff would complete the online resource, be recompensed for their time via their shift roster and would be allocated to attend a face-to-face training day to consolidate their online learning. Due to the amount of information within the package and the requirement for staff to have hours paid back to them for completion, it was viewed as a big investment in management's time and budget. It became apparent to management that some maternity support workers found the theory overwhelming whilst some midwives found "non-midwifery material difficult", there was no formal monitoring of completion. Ultimately the proposed training plan deteriorated. The resource package for training and following up on staff knowledge was never revisited by management. The time required for completion and allocation to a face-to-face training and the cost implications of such will undoubtedly have had an impact on midwifery managers who needed to give priority to maternity safety agendas.

Midwifery managers at the study site believed that the accreditation process was too costly and that UNICEF UK are asking for too much money, they also believed that UNICEF UK were making a vast amount of money from the assessment process which resulted in a reluctance to spend public money on it. UNICEF UK were viewed as having a monopoly of the education programme, this view was reiterated when NHSE refused to allow the trust to develop its own package. The BFI does not only consist of an education package, however the ideas that the study hospital midwifery managers had for developing a local infant feeding package was not investigated in-depth in this thesis.

Lack of training and ineffective planning for the visit resulted in staff forming the opinion that there is an unsupportive culture for the BFI within this NHS trust. Management removing BFI training resulted in midwives and support workers feeling as though they were failing the women in their care and that they were

not doing a good enough job, resulting in role conflict and poor job satisfaction (Hansson et al. 2022). Managers have a responsibility to provide staff training and must be involved in each stage of preparation and delivery of education to ensure that it is meaningful and cost effective (UNICEF UK 2017; UNICEF UK BFI 2024).

9.2.1 UNICEF UK re-assessment visit

It is presumed that it was a senior midwife with responsibility for the BFI who applied for the re-assessment visit, which was completed in the early part of 2018. This occurred 13 months after the expected re-assessment visit date and 24 months after BFI education was removed from training. As discussed, stage two of the BFI accreditation process is to ensure an educated workforce within the unit (UNICEF UK 2017, 2023). UNICEF UK expect that this standard remains in place since initial accreditation was awarded, one element of the re-assessment process is to review documentation relating to staff training, including records to confirm that all staff have completed mandatory training and a review of the education curriculum (UNICEF UK, 2024). The UNICEF re-assessment visit was completed two years after staff training was halted which means the unit is bound to fail on the criterion of an educated workforce (UNICEF UK 2017). Some staff had not had initial BFI education or those who had, had not attended updates, there were no ongoing staff audits and any curriculum plans had been stagnant for at least three years since the previous re-accreditation in 2014. This leads to the question of why this unit applied for the re-assessment visit when these essential elements were not being maintained, whether it was a managerial decision or UNICEF UK were encouraging the re-assessment is unknown. There were no staff training records or curricula available for analysis for this research. Before the unit could progress to full re-accreditation, UNICEF UK required the implementation of mandatory breastfeeding training which was supported with audits and PSR's within six months. This process of auditing staff knowledge is essential for the maintenance of embedding the BFI standards and to provide a form of surveillance of practice standards, they should be performed with staff as a supportive mechanism to aid learning as maternity staff may experience feelings of pressure (Byrom et al. 2021). Byrom et al. (2021) explored how

organisational culture can be influenced by the BFI in a UK maternity unit, their findings offer insights which are relevant to the barriers discussed here.

As highlighted within the findings chapter, in the absence of regular staff training there was an attempt to prepare for the re-assessment visit by updating maternity staff on the BFI standards over a short period of time. The preparation materialised in a flurry of activity by midwifery managers and became a “tick box exercise” that staff were required to complete. Staff described the process as being a rush job, which it clearly was, education should have been ongoing and continuously maintained in the preceding three-four years, which would have prevented midwives ‘fighting around’ attempting to learn the BFI standards. Being provided with the questions and answers to learn was not meaningful, subsequently staff did not rote learn the information as it had no context and not understanding the UNICEF re-assessment process was due to a lack of education and ongoing internal audits. Completion of audits and PSR’s as part of the accreditation process (UNICEF UK BFI 2024), would have ensured that it did not feel alien to staff and would have allayed their feelings of examination conditions and the sole responsibility of failure that they felt. If the BFI was embedded within the maternity unit, staff perception may have been different.

Participants felt a personal responsibility to pass the re-assessment visit for the benefit of the maternity unit, knowing they were not educated to current evidence made them feel uncomfortable and they did not want to let their managers and colleagues down. There appeared to be no strategic direction from midwifery management and staff begrudged this, they did not want to cause detriment to the unit by not passing the assessment. The lack of managerial direction served for midwives to question not only their roles in the accreditation process but what impetus was on managers. They were disgruntled at midwifery management not being regularly present within the ward environment or providing ongoing BFI education to allow them to be prepared, participants stated that they wanted regular education and updates to increase their BFI knowledge. They felt unimportant, with the only priority being

midwifery management “showing off their shiny new plaque and accreditation for three years”.

Maternity staff were negative towards the process of preparation for the re-assessment visit, the visit was compared by most staff to examination conditions, with staff stating they had ‘escaped’ if they were not present on the day of re-assessment. It was unsurprising for staff to learn that the re-assessment criteria had not been met, although UNICEF UK requirements to pass were never officially relayed to staff. Essential requirements for the trust to complete, in the following six months to gain accreditation status were not acted on, resulting in the accreditation status being removed from the maternity unit.

9.2.2 Impact of lack of BFI education for maternity staff

One key impact of the lack of staff education was becoming deskilled and losing competencies. Education is essential for developing knowledge, skills and attitudes of health professionals and determines the quality of evidence-based practice and care that is provided by them (Lehane et al. 2019).

Without regular BFI education and updates (UNICEF UK 2017, 2023; UNICEF UK BFI 2024) staff knowledge and skills will not develop and if not regularly applied to practice there is the risk that staff who are left to their own devices then provide care “off piste”, the meaning of which is to act in a way or “do something different to what is normal or expected”. This has the potential for staff to provide infant feeding support which is not based on scientific evidence. Midwives have a professional responsibility to keep their knowledge up to date and ensure care provision is evidence based.

The Nursing and Midwifery Council (NMC 2018) are the professional body in place to protect the public by ensuring that practising midwives in the UK meet their requirements for training and post registration behaviour and expectations. The NMC (NMC 2018) has published a code of practice which midwives, nurses and nursing associates must uphold, the commitment to professional standards is in their view ‘fundamental to being part of a profession’. It is expected that professionals work within the capabilities and limitations of their competence,

this is a key principle which midwives must also adhere to. In order for a midwife to meet the NMC requirements, one element within The Code (NMC 2018) is to practise effectively ensuring information that is provided to service users is always in line with the best available evidence base, being sure to maintain their own knowledge and skills which are required for effective and safe practice, this does not align with midwives stating that their knowledge is degrading. Alongside this there is an expectation that the skills and expertise of colleagues are respected and when their contribution is felt to be of benefit then they should be referred to where appropriate, this delegation should only occur when the task being delegated is within the colleague's scope of practice. NMC Standards of proficiency for midwives were updated in 2019 (NMC 2019) including the expectations of a newly qualified and what knowledge and skills are expected of every midwife. One key theme in this document is that each midwife has a personal responsibility for their ongoing learning and development, midwives saying that their knowledge degrading due to a lack of BFI training within the workplace demonstrates that they are not adhering to this expected standard. At the point of registration, all midwives are expected to be able to critically analyse and interpret research evidence as well as local, national, and international data and reports with the ability to apply these findings to their practice in order to 'support women's evidence-informed decision-making' (NMC 2019).

Domains three and six in the NMC Standards for proficiency (NMC 2019) focus on universal care for all women and newborn infants where midwives work in partnership with women. In order to meet these domain requirements, midwives must demonstrate their knowledge and understanding of the anatomy and physiology and epigenetics of infant feeding, the implications of infant feeding for both maternal and child health and the importance for early child development (NMC 2019). Midwives must also have the capacity to demonstrate their knowledge of changes to psychological, behavioural and cognitive factors during infant feeding and relationship building. If education is not provided in the workplace, it can be questioned how they continue to meet these domain requirements as per the NMC expectations.

Staff have a responsibility to keep themselves updated with all skills and knowledge as per the NMC standards (2019). Some midwife participants spoke of how their BFI training at university was comprehensive and in depth yet since their employment at the trust, they feel their knowledge is no longer up to date. Whilst a student midwife at university they are provided with information of where to access resources and evidence and how to keep updated with UNICEF UK post qualification, it is not meeting their NMC requirements to allow their knowledge to become outdated. As discussed in an earlier chapter, although newly qualified staff are found to be more committed to the BFI as they are 'ready to learn' the influence of older colleagues cannot be underestimated (Nickel et al. 2013). It is not acceptable for midwives to solely blame their employers for their degrading clinical knowledge.

One area of breastfeeding support that was discussed by staff was a 'hands on' approach. This approach is not supported by evidence and the effect on women can be significant when maternity staff incorporate this approach into their practice.

9.2.3 Impact of lack of staff education for women and babies

Women and babies can be affected by lack of staff education in more than one way. Evidence from both published literature and this research demonstrates that conflicting and inconsistent BFI and infant feeding support information is being delivered alongside non-evidence based practical support such as a 'hands on' approach to infant feeding support. Both elements are discussed below.

One midwife participant appreciated that the BFI provides clear guidelines for maternity staff to follow and appears to be blaming women for stating that they are not receiving consistent infant feeding support information, it is suggested that it is how the women are perceiving the information or that they are not paying attention to staff as to the reasons why it appears to be conflicting. Some factors supporting this view include that midwifery terminology can be nuanced and there is potential for misinterpretation, there may be emotional factors of fear, worry and anxiety of the mother impacting her ability to understand information. Conversely, due to a lack of education, the midwife

may lack the necessary understanding of the BFI evidence base, resulting in a fear of reprisal from management when working out with evidence-based guidelines and taking a defence stance to their practice and blaming women as a defence mechanism (Feeley et al. 2019).

An opinion provided by a maternity support worker participant acknowledges that women may receive many pieces of information, from a range of maternity staff members, which may appear to be different suggestions and conflicting in nature. A systematic review by Chesnel et al. (2022) found that inconsistency in providing breastfeeding information and support was a common theme in postnatal care and that maternity staff will "undertake damage limitation techniques" in an attempt to reassure the woman that any information that has previously been provided is correct and not conflicting, it has merely been delivered in differing ways. This occurs as they do not wish to undermine the woman's belief in breastfeeding and are managing conflicting care and information provided by colleagues.

Regarding evidence-based practice, in this study site not all midwifery managers felt that the BFI made a difference to families. One senior midwifery participant was openly cynical, claiming that the BFI guidance was not always useful to her in practice. The UNICEF UK BFI guidance states that staff should enable parents to build a relationship with their baby which will promote "the best possible start in life" and support effective breastfeeding (UNICEF UK 2024). An example provided by this midwifery participant as to why the BFI was not deemed to be useful was the 'hands on/off' approach to breastfeeding support. Shafer and Genna (2015) noted that maternity care providers "traditionally" adopted a hands-on approach to breastfeeding, which manipulates the woman's breast and the body of the baby, to ensure attachment to the breast occurred. This practice was thought to have developed in response to significant breastfeeding support being required due to "traditional" use of heavy sedation medications during childbirth (Schafer and Genna 2015). Research has shown that when childbirth and postnatal care becomes medialised, mothers do not perceive this to have a direct influence on the behaviour of their newborn infant, however some women reported unsettled

behaviour where they were feeling anxious after a challenging birth (Power et al. 2023). This anxiety could be an emotional factor, which may impact on the processing of information or may influence how maternity staff support breastfeeding.

The literature and evidence that advises against a hands-on approach to breastfeeding was deemed to be unhelpful, for participants in the unit under study, as she "sometimes just wants to get the baby on the boob" (Vicky), thereby fulfilling the need for the infant to feed. This insinuates that the woman is purely a supplier of milk with the midwife being the expert who is present to 'manage' the breastfeeding process, to ensure there was a "functioning breast-baby dyad" (Burns et al. 2013), possibly without regard for the needs of the woman. The reason why this participant felt this way was not explored further within the interview. The hands-on approach might occur is when breastfeeding support becomes task orientated as opposed to enabling parents to build a close relationship with their baby. The assisting midwife has what is deemed as more important duties or there is a need to prioritise other care aspects such as dispensing medications, complete observations or documentation, time constraints are often cited as the reason for hands-on breastfeeding support (Hunter et al. 2015). Breastfeeding support then becomes removed as a component of holistic care. Breastfeeding is viewed as time consuming so when the baby has been 'attached' to the breast the midwife invariably leaves the bedside or room leaving women to feel frustrated with this (Schmied and Beake et al. 2011). For some midwives it can be quicker 'to do' than spending the time to 'teach'.

Whilst the midwife may feel that 'she just wants to get the baby on the boob' this does not meet NMC standards (NMC 2019) which state that midwives must:

> "Promote the woman's confidence in her own body, health and well-being and in her ability to be pregnant, give birth, build a relationship and nurture, feed, love and respond to her newborn infant".

This statement of "just wanting to get the baby on" assumes an unspoken right to access the woman's breasts for the benefit of the baby, Schmied et al. (2011) observed that in this context midwifery care becomes 'breast centred' rather

than woman centred. Where the midwife practices hands on feeding support, they may be seen as the 'expert' with the woman and baby lacking the skills required for effective breastfeeding. The midwives are viewed as possessing the 'skill' which they are proud of achieving (Burns et al. 2013).

What became apparent throughout this study was some midwifery managers find the BFI guidance unhelpful regarding the 'hands off' approach and therefore are cynical of the benefits of it. The evidence and literature that has been published is research with breastfeeding women and how they have felt when experiencing this form of 'support' when it has not been requested (Burns et al. 2013). This demonstrates a lack of knowledge and insight by managers of the BFI standards and the published literature describing the support for breastfeeding women and their feeding experiences. Possibly due to this lack of knowledge of the evidence on which the BFI standards are developed, it was felt by midwifery managers that staff training days did not warrant the time required to allocate staff to them.

A dominant discourse in an Australian study was that midwives viewed breast milk as 'liquid gold' and that breastfeeding was the mechanism for the transfer of this superior nutrition (Burns et al. 2013). Support during the initiation of breastfeeding is a professional domain of midwives (Burns et al. 2013, NMC 2019), as such midwives are fully aware of this professional expectation. A hands-on approach can also occur when the midwife has other important duties or needs to prioritise other care aspects. By 'putting' the baby to the breast they have technically met this requirement, regardless of the evidence that it is unhelpful for women who need to learn how to position and attach their infants themselves ref. Not providing women with the evidence, knowledge and support of how to effectively feed their infants will result in a lack of confidence in their abilities (Burns et al. 2013). Whilst some women may find a 'hands on' approach to be helpful and request it from staff, which for some participants causes conflict between their knowledge and practice, there are women who find it intrusive, demoralising and distressing and that unwanted touch is unhelpful with the invasion of personal space being uncomfortable (Taylor et al.

2019), resulting in a feeling of a ‘disconnected encounter’ with the midwife (Schmied et al. 2011).

Byrom et al. (2021) found that staff tended to practice in a hands-on manner when the ward acuity was high and midwives were going ‘to do’ breastfeeding. Byrom et al’s. (2021) findings match those of Hunter et al. (2015) study where they found that infant feeding support was often ‘provided’ as hands on assistance, they questioned whether this allowed the caregiver to remain in control of the scenario so that the ‘task’ would be finished in the shortest amount of time. Chesnal et al. (2022) found that midwives in Northern Ireland felt there was an expectation for them to practice in a hands-on way to ‘help’ with positioning attachment whilst on the labour ward which they explained was due to the BFI guidelines recommending a breastfeed within the first hour of birth. These Northern Ireland labour ward midwives felt that working to guidelines influence a physical approach to providing infant feeding support.

Prior to the BFI standards being implemented in the study site, participants felt that feeding support had followed a very hands-on approach by staff before women were left to own devices and Daisy discussed the experiences of mothers following hands on care. Student midwives and newly qualified midwives at this hospital have practiced with a hands-on approach when requested to by a colleague, they feel that they cannot decline due to the requesting midwife being their practice supervisor or a higher pay band. Wren suggests that staff may work with the hands-on approach which is from a defensive practice stance (Feeley et al. 2019), they are pre-empting a poor outcome and subsequent need to justify actions or omissions to managers (Feeley et al. 2019).

Not all midwifery managers are convinced that the BFI makes a difference, and that the guidance was not useful with unclear messaging, leading to cynicism. An example given of unhelpful guidance was ‘the hands-off’ approach to feeding support, reiterating the requirement for an educated enthusiastic leader of the BFI to ensure delivery of the correct message. One manager was not convinced that the BFI makes a difference to providing feeding support, but with a national directive to embed the BFI into the maternity service, there needs to

be support and a belief in the evidence supporting the benefits that the BFI can provide to women and babies. UNICEF UK have recommended tailored training for midwifery managers to aid the development of a supportive management team (UNICEF UK 2023). When colleagues openly demonstrated positivity for the BFI there was an acceptance to “be proved wrong” in her cynical view. There is internal conflict with this midwife as her managerial role differs from her role as a midwife working clinically within the postnatal ward. Time pressures and high workload results in occasions where ‘hands on’ support is used.

9.2.4 Management support for staff education

A well-documented facilitator for the successful implementation of the BFI is executive and managerial support for a mandatory BFI education programme (Moore et al. 2007; Walsh et al. 2011; Nickel et al. 2013; Wieczorek et al. 2015; UNICEF UK 2017, 2023; UNICEF 2018; Byrom et al. 2021; UNICEF UK BFI 2024). In 2020, NHSE, NHS Improvement and UNICEF UK BFI agreed a joint financial offer of support for maternity units in England, for three years, with a view of all maternity services achieving full accreditation status by March 2024, thereby meeting objectives as documented in the NHS Long Term Plan (NHS England 2019; UNICEF UK 2020) The LMNS became responsible for providing funds to local hospitals trusts. The midwifery managers within this study hospital embraced this opportunity and employed a band seven BFI lead midwife in 2021. As previously discussed, I was successful in becoming the BFI lead midwife. Findings from the participant interviews had informed me that midwives and maternity support workers wanted BFI training to be provided by management. Policies were developed that were easily accessible for staff, they were clearly structured and supported with scientific evidence. All staff were orientated to these once they had been ratified by the management team. An education curriculum was developed by the BFI lead midwife following training from UNICEF UK, once this had been completed mandatory training was planned and delivered. The outcomes of internal audits and PSR’s informed the BFI team where education was effective/ineffective. The support for the BFI education from midwifery managers had a positive influence amongst staff who were grateful for the education programme, there was highly

positive feedback and evaluation of the training days and reassuring PSR results. Midwives, maternity support workers and neonatal were all equipped with the same infant feeding support skills and updated BFI standards knowledge resulting in a stable and educated workforce. There was an education plan developed for annual BFI updates and regular staff audits.

9.3 Lack of resources

Figure 13 Organisational factor theme: Lack of resources

In 2013, the Department of Health (DH) and NHSE commissioned NICE, to develop an evidence-based guideline focussing on safe staffing within maternity units (NICE 2015). It was recognised that ensuring patient safety and quality of care, whilst allocating financial resources was an ongoing challenge for all NHS services. A systematic review performed in preparation of the guideline found that published evidence and hospital data records were inconsistent and weak regarding the positive or detrimental effect of staffing levels and/or staffing skill mix on clinical outcomes (Cookson et al. 2014), therefore NICE commissioned further research in this area (NICE 2015). Where there were variations in outcomes for women these were accounted for as individual, patient level factors such as age, ethnicity and parity, rather than trust wide variations, however worsening ratios of staff to women had a statistically significant effect

on the healthy outcome for women (NICE 2015) Organisational recommendations include ensuring that midwifery care is individualised regardless of setting and time of the day or week. Infant feeding has been recognised, amongst other factors, as a demand factor for maternity staff (Royal College of Midwives RCM 2016). Turner et al. (2021) completed a systematic scoping review to examine the association between staffing levels and clinical outcomes for women, infants and maternity staff, no significant differences were identified in outcomes when there was an increase in staff numbers (Turner et al. 2021). Staffing levels is a sub-theme for this study within the main theme of a lack of resources and will be discussed next.

9.3.1 Staffing levels

Midwifery staffing levels in the NHS are low across the UK (NHS England 2023) and globally it has been recognised that inadequate staffing levels, as an organisational barrier, can result in staff having little to no time to provide infant feeding support (Nickel et al. 2013). Management participants recognised that low staffing levels was a 'real' challenge and a barrier to providing care, not just infant feeding support.

Staffing levels, specifically low staffing levels was discussed by both midwifery and maternity support worker participants during this study and was identified as a factor which impacted their time. Many participants discussed that low staff numbers throughout a shift impacted the time available to complete their workload, which subsequently resulted in a lack of care provision, namely in providing infant feeding support. Midwifery manager participants acknowledged that there had been ongoing staffing challenges with a regular reliance on bank midwives and support workers. A barrier to BFI implementation that was highlighted throughout this study by participants was the impact that inadequate staffing levels had on the ability of staff to provide an adequate level of routine midwifery care and feeding support to women. One manager participant admitted that at the time of this study, maternity staff did not have the adequate amount of time to "give good care" but she suggested that an increase in staffing levels would not relate to an improvement infant feeding support per se.

Increasing the number of staff may not directly impact infant feeding support as there are many staff who have no current BFI education.

Maternity staff not providing “good care” cannot be ignored. The safety and quality of maternity services has been a national focus and independent investigations have highlighted concerns of staffing levels and subsequent impact on care (Parkin and Balogun 2023). The paper ‘*Safe Staffing’* (Royal College of Midwives 2022) demonstrated that midwifery numbers have not been increasing concurrently with the increases in complexities amongst the population. Safety was a priority over BFI education during staff mandatory training which has resulted in maternity staff providing poor infant feeding support, if any at all.

Lack of resources such as staff and time were suggested by midwifery management participants as the most significant barriers to implementing the BFI standards and providing infant feeding support within this maternity unit. There are regularly shifts with inadequate numbers of midwives allocated; a manager participant stated that when midwifery staffing levels are of the “expected establishment level”, it is viewed as a “luxury”. The luxury of good staffing levels will assist with preventing lack of care. There is a lack of national guidance as to what an acceptable establishment level for maternity staff is, it is service specific. NICE (NICE 2015) support the use of a computer-based tool which informs decision making within maternity services regarding required staffing numbers and supporting skill mix. Staffing and clinical data are the elements on which decisions are based (Royal College of Midwives 2022). An evidence-based review of the computer staffing tool states that there was no evidence validating the methodology that the tool uses or clear demonstrations that the tool has an effect on outcomes (Warttig and Little 2015), although it is acceptable to use in the absence of a suitable alternative.

Midwives and maternity support workers indicated that staffing levels had been a persistent challenge however since the COVID-19 pandemic and the post pandemic recovery the staffing situation had worsened. One midwifery manager participant acknowledged that lack of staff is real and not artificial, another manager participant slightly disagreed. Whilst low staffing levels is a challenge

in some circumstances due to the impact on time, midwifery management discussed that staffing levels had not significantly changed overall, rather it was the increase in complexities that was impacting on the workload for maternity staff.

9.3.2 Workload expectations

Many midwifery and maternity support workers discussed that when fewer staff were allocated to a shift it resulted in a higher workload, this in turn had a direct impact on time that they could dedicate to infant feeding support. There have been occasions when staff have not had enough time to meet the feeding support needs of women due to the need to prioritise other tasks. Both midwives and support workers at the study hospital are required to complete extended roles. The implementation of the European Working Time Directive (EWTD) resulted in an increase in the skill set of midwives (Hutchinson 2014) and there is an expectation of them to complete extended roles which were traditionally the roles of medical staff (Hussain and Marshall 2011). In response to this, the role of the maternity support worker has evolved, within this NHS trust the job description for the band two and band three support workers has been defined by the midwifery management. The formation of the band three support worker team was initially to provide infant feeding support as it was recognised by management that midwives may have other 'tasks' to complete and infant feeding would not be prioritised. In addition to the expectation of having a passion for infant feeding and providing support as the main element of their role, the band three support worker team were required to become competent in clinical skills. Most are grateful for this acquisition of skills and accept that it is positive, this advanced skill set is viewed as being beneficial personally and will benefit the career prospects when applying for promotion or other roles, but they remain despondent about how the clinical workload and the general tasks of the postnatal ward, which is now their priority, has diluted their feeding support role and they feel they are now being used as cheap labour.

There was a sense amongst some support worker participants that the development of the band three team was purely a money saving agenda for management. They were unaware of the evolving role of the midwife in the

wake of the EWTD and believed that the increased expectations of their role were based solely on financial decisions. There was a strong feeling that midwifery managers were utilising the band three team to do the job of midwives to save money, which is not the case. As the role of midwives and band three support worker team has developed there has been a lack of clarity as to who is responsible for which clinical tasks, this leads to ambiguity and blurring of boundaries and expectations (Willocks 2011). Managers were displeased at the accusation that the support worker role expansion has financial underpinnings, they have the opinion that it is a very self-destructive view, to which they are unsympathetic and suggest that any staff member who has that view is "not in the right job". There appears to be a lack of explanation about expanded roles and clarity is required. Midwifery managers would benefit from educating midwives and support workers as to the clinical reasoning of extended roles, which is supported by evidence. This has the potential to quell any negativity between staff groups and allows for effective management of role boundaries and expectations. The additional skill set of band three support workers is welcomed by midwives, especially during a night shift when staffing levels are routinely lower, this can impact the workload of a midwife.

9.3.3 No time

Low staffing levels and increased workload have been identified as barriers to midwives and maternity support workers implementing the BFI, time was often cited. All staff stated that they had no time to spend to support breastfeeding. Time constraints due to inadequate staffing levels were identified as a reason for a lack of care, this was supported with midwifery management agreeing that on occasions maternity staff do not have time to provide good care. Care has been impacted by low staffing levels as midwives and support workers merely pop "in and out of rooms", moving quickly between tasks and women. Sadly, this impacts on how midwives feel towards the women they care for, they feel guilty that they are failing them:

> "I do feel like we are failing them [women] because we can't give them what they need which is really frustrating as a midwife" (Penny)

If staff have no time to give to women and families, this results in a lack of care to a good standard.

Participants would like time to give infant feeding support and women need to receive feeding support and care, however at the time of this study all participants discussed how they have no time to give. There is a question as to the underlying reason of staff stating they have no time, it may be a real factor or an excuse as they feel they are losing or lacking the required skills, potentially due to a lack of training. It could be questioned whether lack of time is an excuse for midwives so as not to admit to their own lack of feeding support skills. Lack of time to provide breastfeeding support is not a new concept, Dykes (2005) studied encounters between breastfeeding women and midwives on postnatal wards in England where it was found that organisational culture of postnatal wards and profound temporal pressures resulted in the emotional and practical support needs of women being unmet.

Becoming task orientated has been highlighted as a coping strategy when staff become stressed or over-burdened, tasks that are prioritised usually being medically focussed (Hunter et al. 2015) with the ability for them to be completed in a short amount of time. There are also many administrative tasks which midwives must complete (Morrow et al. 2013). Breastfeeding and relationship building support can take time as practical and emotional support is required, it is therefore unsuitable to be allocated as a task for completion.

When participants were busy, they made conscious decisions to not inform women to use their call bell to ask for feeding assistance as they were aware that they did not have the time support them. This causes a feeling of a lack of control in their work area and their time, which can be a cause of stress. Not informing women of how to request support demonstrates that staff are not always prioritising infant feeding. It may be at the bottom of a task list or staff have identified this as a coping strategy (Hunter et al. 2015). When staff were unable to return to provide feeding support it resulted in them feeling frustrated and guilty at the lack of care, reinforcing their feelings that they are failing women and babies. When the postnatal ward is full, with just one midwife and one support worker allocated, inevitably there will not be enough time to provide

good care, on occasions women have not been seen by a midwife throughout an entire shift. Midwives and support workers are leaving their shifts feeling frustrated and guilty. Priorities in workload must be made and there have been occasions where women are not encouraged to use a buzzer to ask for assistance as there is the possibility that no staff are available to answer or return once a buzzer has been answered.

The postnatal ward environment was described as a conveyor belt with a high acuity level with noise from room buzzers and telephones ringing, these were reasons why they were distracted when providing infant feeding support. This might seem contradictory as others stated that when they do not have time, they do not inform women about buzzers, this appears to be shift and staff dependent. Women are not receiving the information and support they deserve and are being discouraged from asking for assistance.

Midwives felt ‘pressure’ from their colleagues. One participant spoke about overhearing colleagues ask where other staff members were when providing infant feeding support, phrases such as “where has she been”, “she has been in there for an hour ‘doing’ breastfeeding support, God help her”. This phrase may not have negative connotations, an interpretation being it is an expression of concern for the midwife and that her absence may suggest she requires assistance. Conversely, it could be interpreted that the midwife is being judged for the length of time she has not been present on the ward. Participants discussed how they begin to clock watch and self-inflict a time restraint to feeding support, they question if their colleagues believe them to be shirking their responsibilities owing to their absence from the postnatal ward for a prolonged time due to providing lengthy feeding support. Time pressures were felt by participants to be greater on the maternity unit than in the community setting as there are limited distractions and there is rarely a need to quickly leave the home environment.

Participants believe that women want staff to have the time to sit with them to provide information and listen to and respond to their questions and/or concerns, the hospital environment is suggested as being the place where staff do not always have the opportunity to spend this time with women to listen

properly to them as time pressures are felt to be greater on the postnatal ward than in the home environment.

9.3.4 Facilitating factors

A facilitating factor in this unit is the presence of passionate staff who want to provide good care and can support infant feeding with ease, utilising these skills can encourage knowledge in colleagues also.

9.4 Whose role is it?

In this section, the roles that midwives and support workers have regarding infant feeding support will be discussed. Lack of knowledge of own role responsibilities and of other staff bands was identified as a barrier. There was confusion within the study site as to who was responsible for providing support. This lack of knowledge has been the cause of animosity between staff groups.

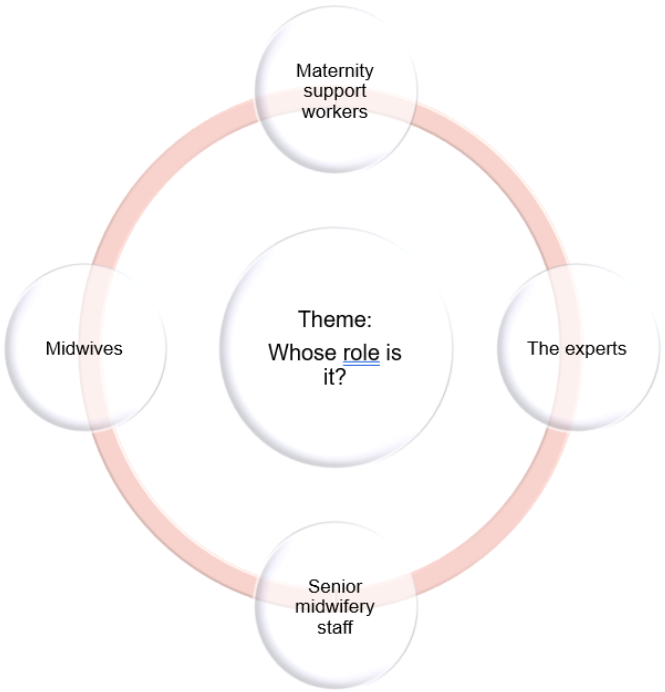

Figure 14 Organisational factor theme: Whose role is it?

9.4.1 Maternity support workers

As highlighted in Sections 7.3 and 7.4, the job descriptions of the band two and band three maternity support workers clearly state that there are infant feeding responsibilities for both staff groups. What this demonstrates is band two

support workers are unaware of their professional responsibilities within this maternity unit, refusing to assist with infant feeding support is not meeting their job requirements. The inception of the band three support worker team, titled the 'infant feeding team' may have resulted in confusion. The band three team were initially formed purely to provide infant feeding support therefore it could be presumed that the band two support team viewed feeding support as a role that was no longer outlined in their job description. Until support worker managers have this discussion with the team it could enable them to continue to refuse. Band two support workers are in a prime position to offer and provide infant feeding support to women and families due to their presence over a range of shift patterns where the band three team are not. Although some have stated that feeding support is not in their job description, as has been highlighted, it is. Midwifery managers do feel sympathy for them stating that midwives' expectations of them need to be realistic, providing basic information for infant feeding is what is expected of them, no complex care. Even this basic request has been met with negative responses which has resulted in midwives not asking for their assistance. It was unclear why members of this staff group are unwilling to assist women. Possibly lack the confidence in their knowledge as a result of no BFI education, there were some who referred immediately to a band three support worker and unfortunately there were some who colleagues viewed as lazy and disinterested, they are met with suspicion when voicing that they are unwilling to help due to lack of training.

Midwifery participants questioned the reason for management forming the band three 'infant feeding team' however, the perspective of the band three support workers was for them to only provide breastfeeding support within the maternity ward. Their presence was never intended to be a replacement for midwives providing infant feeding support.

The expectations of the band three team have developed over time which has resulted in them being equipped with a high skill set although this was not always viewed as a positive by some support workers. There was a feeling that their role had become "muddied" (Daisy) and had lost the focus on infant feeding support with protected time to provide this. Although not explicitly stated

by participants there was a sense of frustration with this change. It appears there were no explanations provided by midwifery managers that clearly explained why their role was developing, if explanations were provided, there may not have been understood within the team. The changes to their role may have signalled a withdrawal of management support for the specialist infant feeding supporter, which is an identity that was highly valued by the original band three team members. To feel that support was lost could be upsetting and frustrating. Additional role expectations have resulted in some support workers feeling as though they are being used as cheap midwives although one midwife participant views the team as eroding the role of the midwife. The view of being cheap midwives did not please managers, they were disappointed and sad to hear this, although they agreed to a certain point. They felt it was an inflammatory thing to say which can be potentially self-destructive in the role and suggested that those band three team members who feel this way are not in the right job for them.

The infant feeding role of the band three team has been diluted and they are not 'just' infant feeding specialists, however their midwifery and band two colleagues continue to view them that way. The team view themselves as having the same level of infant feeding knowledge as midwives and therefore question why they are not providing the support themselves. The band three team are highly valued within this unit and are viewed as an asset, bringing relief to a midwife with a heavy workload. There was a sense that occasionally midwives have used lack of time as a reason to not provide feeding support themselves, some wait for a band three to begin their shift and provide them with a list of tasks for completion. This frustrates the team who do not appreciate being 'waited for' and state that if a midwife had the time to compile a list of jobs, there was time to provide feeding support herself. What may have not been communicated to the team, is that the woman may have requested band three input and with a feeling of malaise, the midwife has not argued. The occasions where the band three team arrive on the maternity ward and colleagues inform them of women requiring their assistance, was viewed as a positive but not by the band three team themselves. They are frustrated with maternity staff colleagues waiting for them to arrive and not fulfilling their own

infant feeding support roles. One band three participant referred to themselves as a walking boob, explaining that walking onto the ward, meeting a request to provide breastfeeding support immediately makes her feel like she is a walking tit. This self-deprecating language could be viewed as a way of asserting confidence in their breastfeeding skills or a parody of themselves by suggesting that their skills apply only to breast related activities. Although not all midwives were willing or happy to refer to the team, some feel that it is a position that they have been pushed into with an increasing workload and not enough time to support women.

Having an option to refer to a band three support worker gives midwives a sense of relief . The expressions of relief used such as “thank God” or the feeling of “offloading” should not be interpreted as a lack of confidence in their own skills or disinterest in infant feeding support. Whilst the language used may cause offence to some, the feelings from the midwives may be an acknowledgement that additional support from ‘experts’ can benefit the midwife, woman and her family. The context and manner are specific to the midwife, there is either genuine relief at workload reduction or relief due to lack of belief in the BFI.

The reasons provided why staff refer to the band three team are not always accepted; they question why they are viewed as being able to do something different to midwives . This can be explained by the message that envelops this maternity unit regarding the team as being feeding support experts and therefore possessing higher levels of expertise, knowledge base and skill set to their colleagues. Their colleagues are unaware that the team do not have any BFI education resulting in the expectation that they are in a position to assist further.

Midwifery and support worker participants recognised that the band three team are over relied on and “dumped” on by midwives which is compounded by band two support workers not providing much, if any, feeding support. It is recognised that the band three support workers are often having excessive demands applied to their workload, routinely there will be one band three

allocated to a shift, all the midwives present on the shift and the band two support worker(s), will request infant feeding support to be provided alongside their routine postnatal ward workload. This is a major cause of frustration for them, they feel 'trapped' by their colleagues who state that feeding support is their role while they disagree and believe it is a role for all whom provide maternity care, regardless of pay banding.

9.4.2 The experts

Infant feeding support is no longer their sole focus, yet the band three support workers are viewed as experts due to their assumed infant feeding knowledge. Whilst there are members of the team who completed peer supporter and counsellor training prior to their NHS employment, there are many who have not and have had no BFI education within the trust, this is concerning as their colleagues seek the expert advice of the band three team. Midwifery managers assume that all maternity staff will naturally refer to the band three support workers as they are viewed as the experts by experience, knowledge base and skill set and that it is normal to seek expertise. That they were viewed as infant feeding support experts within the hospital and that the BFI is their 'bread and butter', was also concerning as it was clearly not the case, they had no additional education or infant feeding training.

Midwifery managers described the band three team as experts with extensive knowledge however they were not provided with training. The band three team are not immune to erosion of their skills and knowledge, this could result in staff who are at risk of working 'off piste' referring to staff who may ultimately begin to work 'off piste' themselves, unless they choose to keep updated with evidence in their own, and hence, unpaid time.

9.4.3 Midwives

Midwives are required to practice effectively, in line with the best available evidence ensuring that they work within their capabilities and limitations (NMC 2018). When a midwife feels that they have reached their limits of competence and expertise, they refer on to colleagues who are deemed as the experts, which in this instance are the band three senior postnatal support workers. There were many explanations provided in this study as to why midwifery

colleagues will refer to a band three. It is documented that infant feeding support is a core part of midwifery care (NMC 2019). Midwife participants discussed that they have forgotten their BFI knowledge and therefore do not know what care they should be providing, there are staff members who are unwilling or not confident in providing feeding support who will be more inclined to refer to a band three support worker. Midwives refer to the band three team when they do not have enough time to provide infant feeding support. They view the band three team as having the same knowledge base as themselves and midwifery management have described them as a team who perform at a high level, therefore colleagues wish to utilise these skills. This is an example of lack of transparency. Not all band three support workers have completed training, there of members of the team with no BFI or infant support training whatsoever, therefore their knowledge base is not equivalent to midwives and not all can perform at a high level.

Midwives are beginning to have mixed feelings about the band three role as they feel their role is diminishing and no longer “feels like a midwife anymore”. Conversely there have been occasions at this study hospital where midwives have had time available to support infant feeding however the women refused this assistance and requested a band three. Midwives become dejected when this occurs as they feel that the women are already aware of the band three team and have the idea that they are more knowledgeable than midwives. When this occurs midwifery participants do not “argue and say I can do it [help]”, they simply refer to the band threes.

Midwives appear to have their own frustrations when women refuse their help, in the belief that the band three team have a higher knowledge level, the title of “infant feeding team” will support this assumption. Being met with “what am I going to do differently to you” places midwives in an awkward position of being rejected by the woman and questioned by the support worker. Not wishing to argue with either, demonstrates that the midwife has taken a defeatist stance which is not in line with her professional responsibilities.

How midwives provide infant feeding support when no band three is present is not clear, some participants state that “they just get on with it”, others state they use visual aids from reputable websites such as UNICEF UK.

9.4.4 Facilitating factors

The band three support workers, with a focus on infant feeding support are strong facilitating factors of implementing the BFI within this maternity unit. The knowledge and training that some of the members of the team gained prior to employment could support the accreditation process. There are midwife participants who demonstrate passion for the BFI and infant feeding support, these are facilitating factors also.

This section provided an examination of each organisational theme and related sub-themes that emerged from the data. Lack of staff education resulted from the removal of BFI education and training ultimately impacting results from the re-assessment visit, deskilling of staff results in an inability to provide evidence-based care and conflicting infant feeding information is given to women in the absence of evidence-based knowledge. Where there is a lack of resources it results in inadequate staffing levels which impacts on care provision, increased workload expectations on staff and time pressures which prevent effective infant feeding support. Confusion about roles was evident. There are band two support workers who are unwilling to assist with infant feeding support when it is clear in their job description that providing infant feeding support is a role they must fulfil, there is a misconception within the maternity unit that the band three support workers are ‘experts’. Some midwife participants felt that their role has diminished with the presence of the band three team and their provision of feeding support.

In discussing these barriers, the experiences and perspectives of midwives, support workers and managers were explored. The section also examined steps taken to address some organisational challenges, such as reinstating BFI education and training, which will facilitate implementation.

In conclusion, this has provided an analysis of the organisational factors influencing BFI implementation in the study site maternity unit. It highlights the

complex interplay of barriers whilst identifying facilitators which can provide learning for other maternity units undertaking BFI implementation.

9.5 Individual factors

There are three apparent individual factors that act as barriers to the successful implementation of the BFI in this maternity unit; 1) the personal and professional feeding experiences of staff; 2) staff demographics and 3) staff misunderstanding the BFI standards or not believing in the principles. Facilitating factors are the presence of midwives and maternity support workers who are passionate about the BFI. Personal and professional feeding experiences shall be discussed next.

9.5.1 Personal and professional infant feeding experiences

A predominant factor was how the personal infant feeding experiences of maternity staff may hinder their ability to accept the BFI standards and the supporting evidence. Supporting breastfeeding may be challenging for staff as their experiences could result in tension between their own feeding choices and the BFI principles (Wieczorek et al. 2015). Staff who formula fed their own children may express difficulty accepting the evidence on the benefits of breastfeeding, potentially due to feelings of guilt about their feeding decisions. They may provide suboptimal feeding support to protect their own emotions regarding their past personal choices. These findings align with previous studies showing tension between staff's embodied feeding experiences and BFI principles (Wieczorek et al. 2015). Maternity staff have an important role in supporting breastfeeding and they must have an awareness of the embodied emotional sensations that women may experience during breastfeeding, they may have experienced them personally (Watkinson et al. 2016) for which they must also demonstrate awareness.

Infant feeding experiences matter, maternity staff who are mothers themselves may have had poor personal feeding experiences which will result in negative emotions. Breastfeeding experiences are important to them and women are known to experience feelings of shock when they are unable to breastfeed, there may also be feelings of loss, anger and grief (Brown 2018). These emotions can apply to any woman who has experienced breastfeeding.

Maternity staff who have had negative experiences, for example their feeding experience ending prior to their intention or being subject to hands on 'support' must be aware of the impact that these personal experiences may have on infant feeding support they provide. Women face a disservice when staff allow their personal experiences to outweigh professional responsibilities to provide evidence-based care (NMC 2019). Schmied et al. (2011) suggest that the BFI helps prevent conflicting advice stemming from divergent personal experiences, educating staff and offering counselling services may aid compartmentalising negative personal and professional experiences and encourage BFI acceptance. With a lack of education there may be resulting degrading of knowledge and skills, in these circumstances maternity staff resort to previous education or outdated knowledge or offer information to women based on their own experiences.

NMC standards (2019) state that midwives must act in the best interests of women and newborn infants at all times. There must be an ability to explain the rationale behind what influences personal judgements and decision making and a recognition that personal factors may unduly influence their own-decision making. Midwives must have the ability to avoid and minimise trauma, it is known that women face grief (Brown 2018) when their infant feeding journey ends sooner than they had planned or they encounter difficulties, therefore midwives are in a privileged position to minimise this potential trauma.

Published research literature has documented that maternity staff who have formula fed stated that their children 'turned out amazing' (Wieczorek et al. 2015). One questions whether this is an attempt to counteract personal guilt they may feel, once they become aware of the benefits of breastmilk constituents. They may experience tension owing to advising women against what they did personally, resulting in contradictory feelings. There may be a lack of education and knowledge in supporting a different feeding method to what they have personally experienced.

Sharing personal feeding experiences has been identified as a barrier to providing effective infant feeding support, this form of information is not based on scientific evidence and may appear to be conflicting if other staff experiences

that have been shared, leading to confusion in women. Contradictory messaging extends beyond the provision of inconsistent or contradictory information, women's expectations and information overload are factors to consider (Hauck et al. 2011). When maternity staff have little to no BFI knowledge, they have admitted to relaying second hand information that they have overheard from their colleagues, these have been situations where infant feeding information has been overheard whilst being provided to mothers or from general conversations amongst staff.

There is a sense among staff that personal stories could lead to confusion for the women owing to the potential for different experiences and stories being discussed by many different staff members. Staff do not all agree with this stance and question whether there are times when women are not getting conflicting advice, but merely feel that the many stories are different, rather than the same information being given in a variety of ways, this is suggestive of the participants blaming the women for 'misunderstanding'. Participants of Schmied et al. study (2011) promote the BFHI or BFI for this reason of confusion, they felt that the standards provide a clear direction for staff, to ensure consistent evidence-based information is provided to women and that any incorrect advice previously given could be discreetly corrected. Midwifery managers have informed staff that this is professionally unacceptable but do not appear to have provided a clear reason as to why for staff to understand.

Older staff who have worked within the study site for numerous years were viewed as a potential challenge to implementing the BFI, their colleagues viewed them as either very experienced or stuck in their ways with voicing their opinions of 'this is how we have always done it' and that care they provide 'works' when referring to breastfeeding support. Senior staff felt that it is difficult and challenging to highlight to this group of midwives that the BFI is providing up to date evidence and that it would be hard to change their attitudes. This difficulty to change attitudes is frustrating colleagues as the information and care they are providing is not evidence based. Where older staff were felt to hold influence within the maternity unit, there was less commitment of all staff to accept change (Wieczorek et al. 2015), highlighting the benefits of change

champions. Older midwives are viewed as being difficult to approach to update their knowledge due to their attitudes towards the BFI (Allen and Anderson 2019). It has been found that they are stuck in their ways and have formed their own opinions of 'this is how we have always done it' viewing the BFI standards as new and unnecessary rubbish, it can be hard to change these attitudes (Nickel et al. 2013, Wieczorek et al. 2015). These older staff are those who eye roll at BFI advocates. The challenge to changing these attitudes lies in the requirement for staff to accept that how feeding support is provided has developed with emerging evidence. Accepting a change to working practices may be viewed as admitting that how they have practiced and continue to practice is incorrect, rather than viewing the change as beneficial for women and babies.

These opinions of older staff and senior midwifery staff echo the findings of Nickel et al study (2013) which found that older midwives were stuck in their ways with the view of 'what we do works'. Both the findings of this study and those of Nickel et al. (2013) and Taylor et al (2019) highlight that these attitudes towards infant feeding support have not changed for at least 18 years. Wieczorek et al. (2015) discussed that older colleagues who participated in their study considered the BFI to be 'unnecessary new rubbish' which may explain the ongoing attitudes of staff within this study site. Their study discussed that within maternity units there was a culture of staff not understanding that infant feeding knowledge was important (Wieczorek et al. 2015). Colleagues were felt to view the BFI as an ideal set of standards only (Walsh et al. 2011, Wieczorek et al. 2015), this feeling of being an 'ideal' was echoed by the participants of this study which demonstrates that this view has not differed for 12 years. This idealistic view has resulted in staff not referring to the BFI regularly, resulting in outdated and anecdotal information being imparted to women.

There are midwives and support workers who actively avoid providing breastfeeding support and state that being in a room to assist or working on a postnatal ward is not "where they want to be", when these staff members are referred to and requested to provide feeding support they have replied with "I don't do breastfeeding". This attitude and response is frustrating and

challenging for their colleagues. Band two support workers are accused of using the lack of workplace training as an excuse not to support women, their colleagues suspect they personally have no interest in breastfeeding, it has been evident to some participants that these 'uninterested' support workers and midwives have not breastfed their own children. This 'excuse' is likened to opinions of maternity staff stating lack of time as an 'excuse' not to provide feeding support. The refusal to assist with breastfeeding support is another element which is causing disharmony between staff groups, the workload of the band three team increases resulting in some of them forming the view that maternity staff with an attitude of "I don't do breastfeeding" should either not be employed or dismissed from their role. There were specific incidents highlighted by participants of band two support workers routinely providing breastfeeding mothers with bottles of formula milk, it is unknown whether this is due to their lack of interest in the women's feeding choice or a personal discomfort with providing feeding support. The phrase "I don't do breastfeeding" is interesting. Maternity staff are being asked to support breastfeeding, not "do it", this highlights a lack of knowledge regarding how breastfeeding support is provided and one has to question whether it is believed that a 'hands on' approach is thought to be the norm which is resulting in a refusal of staff who do not wish to touch breasts. These staff members should be offered education and an opportunity to discuss and reflect on their personal experiences. Targeted education on their professional responsibilities could also help overcome refusal behaviours.

The personal and professional attitudes of staff can have a clear impact on the provision of breastfeeding support, ward maternity staff can attend training and have discussions with senior members of staff with responsibility for the BFI. Management need to be aware of how their internal conflicts between their professional role as a manager and as a ward midwife impact care for women and babies.

9.5.2 Staff demographics

Staff demographics are identified as individual factors which influence acceptance of the BFI, these include age, experience, values, night or day shift

workers and newly qualified staff. The attitudes, beliefs and experiences of maternity staff regarding breastfeeding and breastfeeding support varied by age and experience.

Younger and newly qualified midwives have recently been educated with the current BFI evidence and will adopt these principles into their midwifery care, they have not yet developed work patterns that do not support the standards. As has previously been discussed, maternity staff who have less than ten years of midwifery experience were more committed to the BFI than older colleagues as they recognise the benefits of the programme for women and staff. The literature included in the review suggested that older staff were those with 15 years of experience or more, this group of staff were deemed to have a great influence over younger staff resulting in a decreased ability to fully embed the BFI within a maternity service ref. Older staff should be included in the planning and implementation stages to increase their knowledge and to dispel their views of the BFI being “unnecessary new rubbish” ref.

Both the literature review and this study have highlighted that there is a feeling amongst maternity staff and midwifery managers of differences in knowledge between staff who work day shifts or night shifts (Nickel et al. 2013). Managers are of the view that when there is a postnatal lead midwife and band three support worker present in the ward environment the BFI principles are being protected, the lead midwife and band threes are viewed as being the most up to date with knowledge, however what should be clear to management is that postnatal lead midwives have had no regular workplace training either. There is no separate and specific workplace BFI education at this trust which is purely for lead midwives and the band three support workers, their knowledge will also erode threatening the protection of the BFI. Management are not aware of the level of training or knowledge that maternity staff have, there are merely expectations and presumptions.

Participants discussed that night shift staff are viewed as having their own culture and a different dynamic to day shift staff, midwifery manager participants discussed that they work a ‘certain way’ which has become their custom and practice (Furber and Thomson 2006; Nickel et al. 2013). The night staff team

talk of a camaraderie amongst themselves and say that there is more partnership working at night, but some admit they are unaware of how a day shift operates or how day staff interact with each other. Their custom and practice way of working is explained as staff being fully aware of the BFI standards and feeding support guidance that is required to be provided but that they do not have the necessary skills which allows “bad habits” to creep in, which do not protect the BFI messaging. This recognition of bad habits and lack of skills is not actioned, no change is enforced. It is clear that night shifts are when incorrect feeding support is provided and care given which does not align with evidence-based guidance, yet it is being allowed to continue.

One night core staff member feels that they utilise their breastfeeding support knowledge and skills much more than day shift staff due to the absence of a band three support worker however they acknowledge that there are times when they are too busy to provide support which impacts the women and maintenance of their support skills. Two participants stated that parents are vulnerable at night and require feeding support resulting in a top up being more likely throughout the night. Literature supports the belief that the end of a night shift is a time when formula milk is likely to be used as it is less energy consuming for staff than providing breastfeeding assistance. It is unsurprising to hear that within this maternity unit there have been examples of care during a night shift such as formula supplements being given to breastfed babies, or, in breach of The Code (WHO 1981), women being provided with full bottles of formula milk as a “just in case” precaution as staff do not want to ‘pressure’ mothers into breastfeeding. (Furber and Thomson 2006).

9.5.3 Maternity staff who do not believe or understand

Women are deemed at being placed under pressure to breastfeed when maternity staff rigidly apply the BFI to their practice (Schmied et al. 2011). Participants of the literature review studies used examples of not being ‘allowed’ to provide formula milk to families as this would assist the woman to ‘help her to keep going’ ref. Midwives admitted to ‘breaking the rules’ by removing the baby from the room for a couple of hours so that the mother could rest and voiced that the BFHI was too rigid regarding rooming in ref. Midwives at this study site

have encountered support workers, only during night shifts, who feel that they are putting pressure on women by offering feeding support as they believe they are making mothers feel like they 'have to' breastfeed. Band two support workers perceive midwives to be forcing mothers to breastfeed against their wishes. This has not been voiced by women at this maternity unit. With no evidence, it is an unsubstantiated opinion which must stem from the support workers personal beliefs about breastfeeding.

One midwife stated that as a supporter of the BFI she is viewed by colleagues as forcing women to breastfeed and is a "breastfeeding Nazi" although she "tries not to be like one". A paediatrician participant of Wieczorek et al.'s (2015) study discussed that when maternity staff follow the BFHI standards they can be deemed to be 'forcing' women to breastfeed and were labelled as the 'breastfeeding Taliban'. The opinion of one senior midwife participant of this study was that the BFI was really structured with the information and care that maternity staff are to provide to women, it was felt to be "quite forcible" and "constantly about breastfeeding" with this is how "you *will* feed your baby" and that staff should not be discussing formula. The current BFI UK standards (2012) document safe and responsive formula feeding so it is unclear as of which BFI standards her opinion is based.

9.5.4 Facilitating factors

The band three support workers are also a facilitating factor regarding personal and professional experiences. The knowledge and training that some of the members of the team gained prior to employment could support with increasing their colleague's knowledge and providing support for them in difficult scenarios. There are midwife participants who have counselling and advocate roles, these staff members are facilitating factors also.

This section has highlighted the influence that individual staff factors can have on successful BFI implementation. While organisational factors such as policies and guidelines to guide care and resources matter, change ultimately relies on the beliefs, attitudes, experiences and practices of individuals (Nilsen et al. 2020) as well as management enforcing expected job roles and responsibilities which is documented within job descriptions. Ongoing staff education, training

and support focused on overcoming individual barriers will be essential for fully embedding BFI standards into this maternity unit. Adopting the BFI standards into individual practice is key for providing optimal, evidence-based infant feeding support.

9.6 Socio-political factors

The successful implementation of the BFI relies not just on organisational and individual factors but the broader socio-political context. This section examines how elements of the socio-political landscape in the UK create barriers and facilitators to effective BFI implementation. The role of UK media messaging undermining breastfeeding and criticising BFI supporters is scrutinised and discussed in depth.

Having governmental and professional body support for breastfeeding and recognition of the BFI is a facilitator to successful implementation. Official policies and directives supporting the BFI should demonstrate that there is strong support from the government. Following the 'Call to Action' (UNICEF UK 2016), the BFI now has recognition in policy documents across the four UK nations, these polices are discussed in the national context of BFI section of this thesis. A major barrier to the success of the BFI is lenient government adherence to The Code (WHO 1981).

Collaborative working across maternity organisations and regions improves accessibility of breastfeeding support and approaches to implementation, advocacy groups can assist with disseminating policies and directive. At the time of this study a local infant feeding network was established which had a network of NHS BFI lead midwives, health visitors, peer support groups and local council managers with a strategic aim to ensure all services were at the same level of BFI accreditation.

9.6.1 Attitudes of women and relatives

The attitudes of women and their relatives will influence infant feeding decisions and the level of support they require (Nickel et al. 2013). Cultural beliefs and practices are an important element to consider when providing BFI information to women.

The perceptions of women's cultural beliefs is important. Regardless of staff reassurance, there are circumstances specific to a woman's culture that she will follow, in these cases staff must respect the culture and not force them to 'go against' their cultural practices. This could result in discord between informed choice and women's choice. Formula milk is frequently brought into the hospital prior to birth as there are cultures who believe that the baby will require it, this decision will have been made in advance, highlighting the importance of antenatal BFI education. In some cultural practices, women may be less likely to accept information from maternity staff and follow advice from their mother or mother-in-law. Formula feeding may be chosen despite the efforts of staff to promote and support breastfeeding, resulting in staff stepping back and stating that 'at the end of the day it is the mother's choice'(Nickel et al. 2013). All women must be provided with evidence-based infant feeding information, in a sensitive manner with an honest discussion to ensure that a truly informed decision has been made.

9.6.2 UK media influence

Media messaging is undermining breastfeeding and the BFI, an analysis of UK media coverage found frequent use of derogatory terms like "breastfeeding mafia" and "breastfeeding Nazis" in describing BFI supporters. This messaging stems from commentators' personal frustrations with breastfeeding difficulties. By labelling advocates as oppressive, the media narrative frames the BFI as forcing women to breastfeed against their wishes. However, BFI principles in fact promote informed choice and responsive formula feeding (UNICEF UK, 2012).

The media stories suggest common barriers to successful breastfeeding like inadequate infant feeding support. Vilifying those providing the support deflects from addressing systemic gaps impeding women's feeding choices. The media's disproportionate influence perpetuates cultural formula feeding norms. Countering this narrative through positive breastfeeding portrayals is needed to create a supportive rather than oppositional culture. It is not just the media who perpetuate this language. In a study by Walsh et al. (Walsh et al. 2011), participants who were employed at non-BFI accredited hospitals referred to

maternity colleagues who supported breastfeeding as bullies and “breastfeeding Nazi’s”. Similar language was used in Wieczorek et al.’s Study, where paediatricians referred to maternity staff who accept and work within the BFHI guidance as ‘forcing’ women to breastfeed and labelled them the “breastfeeding Taliban” (Wieczorek et al. 2015), as highlighted by a study participant, this term continued to be used as recently as 2020-2021.

The following discussion highlights where the British media refers to the terms ‘breastfeeding mafia’ or ‘breastfeeding nazi(s)’. It will follow a chronological timeline. The British media here refers to newspaper articles, magazine articles and statements made on online platforms such as Twitter. The newspaper and magazine articles that have been included here have been written by freelance journalists who deliver ‘compelling opinion writing’ (The Guardian, 2023).

The title of the first article, ‘Sorry, breast is not always best’ was in response to a statement that had been made by a ‘supermodel’ who was of the opinion that ‘there should be a ‘worldwide law compelling mothers to breastfeed for six months’. The journalist disagreed with this opinion and responds by stating that ‘breastfeeding is not the most natural thing in the world for mothers, and that women must be allowed to make their own choices’. In an attempt to support this argument, there is a hyperlink to follow to a very brief abstract of a Norwegian study, also published in 2010. The title of this study is ‘Baby formula as good as breast milk, claims study’. The newspaper author attempted to reference this study in a bid to support her statement that ‘breast milk formula’ is becoming closer to having the same nutritional properties as breast milk, with an argument being made that it is ‘more or less equal’. Neither the article nor the study provides a robust evidence base. There is an evidence based response from a lactation consultant however this was not easily found in the public domain during the initial search for information, it became visible when a targeted search for the journalist was performed and then the response was more than halfway down the results page, which demonstrates that it would not be easily located during a rudimentary search.

A 2011 article with the striking headline of ‘Stop bullying mothers about breast Vs bottle: the breastfeeding mafia has to take a step back from their strident

absolutism', appears to be 'supported' by a direct quote, although not referenced, from 'child health experts'. These 'child health experts' are reported to have said 'contrary to previous advice', that exclusively breastfeeding for the initial six months could lead to iron deficiency and coeliac disease and therefore mothers should not solely breastfeed and if 'necessary' could begin to wean their babies from four months of age. The lack of reference to the literature by the author highlights that there is a possibility that she has not read the article herself. The claims regarding iron deficiency and coeliac disease are not as clear cut as have been documented within this newspaper article. Accessing the original journal article provides a clear explanation, it also highlights that the majority of the journal article authors have performed consultancy work and/or received research funding, from companies manufacturing infant formulas and baby foods in the three years preceding their article. The journalist wrote that she hated breastfeeding, she makes reference to the postnatal ward 'breastfeeding team' who, in her opinion, nag and bully mothers, she then refers to them as the 'breastfeeding mafia'. It could be assumed that the author is placing her anger, due to lack of initial infant feeding support and subsequent poor experience, on the 'breastfeeding mafia' with an attempt to support her opinion with, what is, incorrect information. Unfortunately, the fact that the 'evidence' that has been quoted by 'child health experts', is not correct and has not clarified for the general public, has resulted in misinformation being provided into the public domain. Opinions regarding exclusive breastfeeding duration may have been formed on the basis of this article.

The terms 'breastfeeding mafia' and 'breastfeeding Nazis' then became more popular within the media and celebrity culture.

In the same year, a headline within a celebrity magazine, 'revealed' how a celebrity had to 'hit back' at critics, who responded to her article where she discussed her struggle to breastfeed her daughter due to an inability to provide enough breastmilk. The situation here involved her pre-term baby who was being cared for within a neonatal unit, the advice that was given by a paediatric consultant was to use formula milk, in order for an intravenous treatment to be discontinued for the baby. Critics called her 'lazy' and 'vain' in response to her

stopping breastfeeding. Again this highlights a potential lack of infant feeding support for this mother and baby dyad. There may not have been enough input and information about successful expression of breast milk and increasing breast milk supply, provided by both maternity and neonatal staff.

Also in 2011, a female singer was deemed to have a 'wicked sense of humour' by using the online platform Twitter to announce that she 'won't breastfeed' her baby. This was met by her Twitter followers suggesting that she should 'never admit that in public' and comments included 'let's hope the breastfeeding nazis aren't following you'. In an aim to quash these comments, there was a statement released to inform her followers that she did have 'every intention' to breastfeed her baby but that the 'point' of her original Tweet was 'merely a joke because she fancied antagonising the milk mafia'. The same year saw another celebrity take to Twitter to request that the 'breastapo' stop making new mothers feel guilty when they 'stop breastfeeding early'.

In 2013, a newspaper columnist, who is also a well-known television personality, wrote an article where the word bully appears again, her headline 'Don't bully new mums on feeding' appears to echo that of the 2011 article above. The article discussed her personal experience following the birth of twins, ultimately she 'did not produce enough' breast milk and was 'urged' to formula feed. Throughout her pregnancy she had received National Childbirth Trust (NCT) information and had wished to breastfeed her babies, however in her words 'they wouldn't latch on properly'. It was the 'nurses who test weighed her babies before and after every feed to demonstrate that they were not getting enough milk', this is where the 'urging' to bottle feed formula milk arose. The term nurses may indicate that the twins were being cared for within a neonatal unit rather than a postnatal ward, by midwives with infant feeding support training, but she is not clear in her article. Throughout her postnatal stay, it is claimed that a group of 'smug mothers' from the La Leche League (a grass roots organisation who were founded by a group of mothers who wished to support breastfeeding friends. The group has developed into a worldwide network offering breastfeeding information and encouragement), 'boasted' about how they successfully breastfed their own children. It is not clear how or

why this group was present within the postnatal ward as they are not routinely present to provide infant feeding support, unless requested by the mother/family. This group of mothers were then labelled 'breastfeeding Nazis' and that 'despite their pressure', her twins were then bottle fed who then 'thrived'. It can be interpreted that it is this group who are being referred to as those who 'bully new mums on feeding' and who are 'piling on guilt trips to women who can't (or won't) breastfeed', she also writes that encouraging breastfeeding 'reared its bossy head decades ago'. It appears that this is another situation where a new mother has faced a lack of infant feeding support, the same as the story within the celebrity magazine, if babies do not latch at the breast effectively, there will not be an adequate supply of breastmilk. The NCT information in this circumstance appears to have not been effective in practice and it seems that this mother is placing her anger on those who have successfully breastfed, by labelling them as 'breastfeeding Nazis'. A breastfeeding counsellor published an article in a bid to explain that providing infant feeding support to those mothers who wish it does not mean she should be labelled as a 'nipple nazi'.

In 2015, an outspoken journalist who is notorious for voicing her controversial views on many topics, spoke out about breastfeeding, airing her view that breastfeeding should be 'banned in public places' and dubbed 'breastfeeding mums' as the 'mammary mafia' stating that she was 'sick of them'.

2016 sees the term 'bully' being used again. The headline for the article, 'Bullied into breastfeeding: rise of the midwife mafia?'. The journalist in this case discusses the hours that they spent with health care professionals and family members where she was questioned about her 'reasons for wanting to jeopardise her son's health and future' by choosing not to breastfeed. The midwives were then referred to as the 'breastfeeding mafia' who are 'hard-nosed enthusiasts bullying mothers to conform to the 'correct' method of feeding', she questions within the conclusion to her article whether 'the pressure to breastfeed is actually causing women to quit'.

A year later, 2017, another celebrity spoke to the media about her experience in 2010. It was reported by the newspaper that she had been a 'victim of the

breastfeeding bullies' however when reading the article these words were not said outright by her. What was stated by the celebrity was that she felt 'a lot of pressure was placed on her which made her feel like a failure'. The original 2010 article was accessed where it is documented that the main reason for this celebrity to stop breastfeeding after three weeks was that she 'did not want to feed in public due to being recognised and the media taking photographs whilst she was breastfeeding'. Another reason provided by her was that she 'didn't have enough milk and her husband wanted to feed the baby'. Her final sentence of the 2010 article states that 'midwives can be rude and abrupt to women who chose not to breastfeed'.

Since 2018 there appears to be a trend towards promoting breastfeeding in a positive manner. Another celebrity magazine, different from the one mentioned above, reported on, with photographs about a supermodel 'walking the runway' breastfeeding her five-month-old baby. This same magazine in 2023 designated their 'body confidence' section to reporting on 'celebrities who have proudly normalised breastfeeding', they then show photographs of 34 screen shots of celebrities who are either breastfeeding or expressing breast milk with a tagline that these are 'famous faces who are reminding 'us' that breastfeeding shouldn't be a taboo'.

The three celebrity mothers who have published articles within newspapers and magazines all have the same complaint of their infant feeding experience, they all say that they could not or did not produce enough breast milk. These stories were documented between 2011-2013. UNICEF UK introduced the BFI to the UK in 1994, these 'Ten steps to successful breastfeeding' were reviewed in 2012 due to the emerging evidence base of the wider benefits of breastfeeding and early relationship building. It could be argued that prior to 2012 the previous standards may not have been clear for maternity and neonatal staff regarding effective positioning and attachment to aid milk transfer and a subsequent breast milk supply.

Strident absolutism can be viewed as presenting a point of view in an excessively forceable way from a position of centralised authority. The terms 'breastfeeding nazis/mafia' have been applied to a wide range of people.

Breastfeeding mothers, whose aim is to support others wishing to breastfeed themselves, breastfeeding support workers and midwives have all been labelled with these derogatory terms. If not these terms, then there is an accusation of them being bullies who either make new mothers feel guilty for not breastfeeding or for stopping 'breastfeeding early'. It is not only within the media reports where this term is used. It is recognised by participants of this study that those who promote breastfeeding are viewed as being 'breastfeeding nazis' by both their peers and the women they provide care for. This particular participant who is passionate about breastfeeding and keep themselves updated with emerging evidence, is acutely aware of the media articles and cultural opinion and whilst her peers have not outright called her a 'breastfeeding nazi' she has labelled herself it due to their dismissive actions towards her.

All media stories above have resulted from personal experiences of poor infant feeding experiences which sadly demonstrate that evidence-based care was not provided to them demonstrating a nationwide issue of effectively implementing the BFI.

Socio-political factors exert a strong influence on BFI implementation through policy endorsement, cultural norms, and media messaging. A truly supportive culture requires government commitment, education of the public regarding the benefits of breastfeeding and human milk. Transforming both practice and culture is necessary for the BFI to reach its full potential in enabling women to achieve their infant feeding intentions.

9.7 Theory of change management

Health care organisations must embrace change as a strategic necessity (Gordon and Cleland 2020). Central to the success of any change initiative is the role of a change manager, who is not only responsible for influencing and guiding the process but also for orchestrating every phase of the transformation. This includes planning, developing strategies, leading initiatives, evaluating progress, assessing impact and providing ongoing support within the organisation to ensure sustainability of the change (Phillips and Klein 2023). Importantly, the communication of policy and change intentions to staff is a

time-intensive process which requires clarity, consistency and repetition to achieve understanding and buy-in (Moore et al. 2007).

Conventional approaches to organisational change and development often assume that change occurs when policymakers, leaders or managers alter an organisation's vision or procedures. However, this top-down approach may not always achieve its intended outcomes and can provoke resistance from individuals (Gordon and Cleland 2020). This can be evident in the complex context of healthcare education. Organisational readiness for change hinges on the collective commitment and co-operation of all staff members, regardless of pay band (Moore et al. 2007) This means cultivating an inclusive culture where individuals are motivated and equipped to contribute to both learning and implementing the change is essential.

Identifying and empowering maternity staff advocates, such as those who are keen to champion the BFI, to be change agents, can bridge leadership and workforce perspectives, fostering trust in the BFI and engagement with the standards amongst their peers. Ultimately, a well-coordinated change management system acts as a crucial organisational facilitator, aligning resources, reducing resistance and embedding change into the fabric of the organisation (Semenic et al. 2012). Commitment is required from all levels of staff within the unit to successfully implement the BFI.

Midwifery managers, in conjunction with a local university, were motivated for the completion of this study. Losing BFI accreditation status meant that previous time and money spent was wasted. Students were also placed at the unit whose education is underpinned by the BFI. The underlying question was 'why was the BFI difficult to implement in practice?'. These study findings and recommendations have answered this question.

Chapter 10 Conclusion

With published evidence demonstrating the benefits of breastfeeding for the health of women and babies (Victora et al. 2016; Fallon et al. 2019) and the UK government making it a requirement for all maternity units to be accredited to BFI standards (NHS England 2019), a need for research in a local maternity unit that had recently had their accreditation status removed by UNICEF UK was required. Maternity and neonatal unit staff were not equipped with the BFI knowledge to meet the UNICEF UK BFI re-assessment criteria. There is a dearth of literature focussing on the barriers and facilitators of the BFI at local and country levels in the UK (Semenic et al. 2012). This aided the formation of the study aim and objectives.

The aim of this study was to identify the barriers, challenges and facilitators to successfully implementing the BFI standards within a maternity unit. The study objectives to meet the aim were to explore the views and experiences of maternity staff when working with the BFI standards in practice, and to explore the views of infant feeding lead staff members and midwifery managers regarding the implementation of BFI standards within their maternity organisation.

A qualitative case study approach was the methodology chosen, researchers typically apply this approach where the research aim is to explore and understand the meaning that individuals or groups attach to a social situation, in this case the social situation being the BFI. Semi structured interviews were competed with maternity staff. Owing to the COVID-19 pandemic, interviews took place online and direct observation as a data collection method had to be postponed due to mandated face coverings within maternity units. Document analysis of all maternity staff job descriptions was completed to support and clarify data collected during the interviews.

The key findings from this research are similar to those from the literature review which demonstrates that little has changed globally since 2006. Specifically for this maternity unit it was found that one of the main barriers to the successful implementation was the withdrawal of mandatory BFI training for all maternity staff. Regular training and internal monitoring of staff via audits

and practical skills reviews, would have ensured that the re-assessment criteria would have been met. Funding constraints were the reason provided for withdrawal of staff training, when national funding to continue the accreditation became available, this was embraced, and the process was accepted and supported by midwifery management. The local agreement for funding provision was for a period of three years, commencing Spring 2021. Lack of resources is a real factor which hinders BFI implementation and are interrelated. Staffing levels have been described by ward maternity staff as low which has a direct impact on individual workload, when staff have a high workload, they have little choice than to become task orientated. Infant feeding support also becomes a task to complete but is usually placed at the bottom of the list with 'quick' tasks being made the priority. Postnatal care continues to be viewed as a 'Cinderella' service, reflecting an impoverished status at the end of a conveyor belt of care and a low status within the health care hierarchy (Dykes 2009). This busy end of the care line for women means that maternity staff are rationing their time by working as efficiently as they can to get their tasks completed. Supporting infant feeding can be time consuming, support can last anywhere between five to forty minutes which explains why pressurised staff will place infant feeding support at the bottom of their workload 'tasks' (Dykes 2009). High ward acuity with noisy buzzers and telephones create a distraction for staff, who are reluctant to be present in a room for a prolonged period of time supporting breastfeeding. This reluctance is partly through fear of being judged by colleagues who have been heard to question where midwives are if they have not been visible on the ward for some time.

Workload has not only increased for midwives, but the support worker teams have also felt this impact too. The band three support worker team can feel over-relied on and have all infant feeding care 'dumped' on them. They are viewed as the 'experts' within the unit due to additional training some of the team have, there are newer members of the team who have had no training. An analysis of job descriptions highlighted that providing infant feeding care is a responsibility for all members of staff, regardless of band. Refusal to provide care or provide non evidence-based care could result in repercussions from management. The increase in workload has a knock on effect of staff having no

time to provide infant feeding support, there are occasions where staff leave the ward and they have either not managed to return to a woman or where women have not been seen by staff once throughout an entire shift. It is every staff members role to provide infant feeding support and it should not be delayed while waiting to refer to other staff groups. An increase in education and knowledge will increase staff confidence in their ability, the BFI provides a framework to guide evidence based care that should be tailored to each individual, it is not a set of prescriptive steps to follow. Passionate staff who have a belief in the BFI should be embraced and supported to be change champions and to provide support and knowledge to their colleagues. For midwives, there is a professional responsibility to keep themselves updated as per the NMC Standards of Proficiency (2019), this negates allowing BFI knowledge to erode under the guise of no workplace training. As well as passionate staff, support and commitment from midwifery managers and senior executive management is necessary, the BFI guardian is in place to protect the principles and accreditation status.

Personal and professional infant feeding experiences should not impact care provision, opportunities to discuss any negative thoughts and feelings towards breastfeeding support should be utilised. Women face grief, anger and feelings of loss when their feeding experience is not how they envisaged, so as health professionals there is a responsibility to minimise this trauma.

Evidence is evolving therefore accepting it into daily practice is not admitting that previous care has been inadequate or that personal infant feeding choices were wrong.

There is a strong formula feeding culture in the UK which requires commitment of staff and the community to change. Derogatory terms are still being applied to proponents of breastfeeding which is compounded by the UK media messaging.

Successful implementation of the BFI relies on midwifery management support and funding for the process. Staff education and ongoing auditing will ensure knowledge is embedded at all time. Feeding support is the responsibility of all

staff member regardless of band. Facilitating factors should be embraced to increase knowledge amongst staff, women and the families in their care. Maternity staff within this study site who provide direct infant feeding support are yearning for education and training, some have explicitly asked for it during their interviews, many believe in the evidence that supports the BFI and want to provide women with evidence based care.

10.1 Recommendations

Recommendations for this study site which will aid with successful implementation of the BFI have been categorised into short, medium and long-term actions.

10.1.1 Short term recommendations

- Ensure that job descriptions are clear and that UNICEF UK BFI responsibilities are clear for all staff banding levels.
- Midwifery management to recognise BFI training as essential and to reinstate a structured BFI training programme with mandatory induction, annual updates and tailored learning by role for maternity and paediatric staff.
- Midwifery managers to present the BFI Initiative to the NHS trust executive board including the clinical, cultural and reputational benefits of UNICEF UK BFI accreditation.
- Gain formal endorsement from the trust executive team and secure sponsorship by appointing a BFI guardian who holds a senior leadership role within the trust.
- Integrate BFI responsibilities into the BFI guardians job description to ensure visibility of the initiative.
- Recruit a dedicated BFI lead midwife to oversee BFI accreditation strategy, education, evaluation and audit ensuring they work closely with clinical governance and workforce teams.

- Enable the BFI lead midwife to deliver bespoke BFI leadership workshops for midwifery managers and the BFI Guardian, ensuring they are equipped to cascade key BFI messages and lead by example.
- Embed BFI training into workforce plans with clearly allocated time and budget to ensure consistent attendance.
- Ensure infant feeding principles and BFI standards are clearly referenced in all relevant clinical policies and protocols.

10.1.2 Medium term recommendations

- There are passionate staff within this trust who support the BFI. Identify these individuals and with the support of the BFI lead midwife, educate and train them to be BFI change champions within the maternity unit to act as role models and provide peer support.
- Midwifery managers and senior staff to regularly speak about BFI in executive, strategic and ward level meetings, be visibly involved with and supportive of the initiative.
- Use blended learning mediums such as BFI online modules, in-person practical skills reviews and face to face teaching.
- Launch a trust-wide internal communications strategy to regularly update all NHS trust staff on BFI accreditation progress.
- Utilise ward newsletters, staff briefings and intranet dashboards to share accreditation timelines, milestones and feedback of best practice case studies.

10.1.3 Long term recommendations

- Support reflective practice sessions and offer facilitated counselling sessions for maternity staff to explore personal infant feeding experiences, especially for those with unresolved grief or trauma related to their own infant feeding experiences.
- Formalise referral pathways to occupational health or external counselling services to support emotional wellbeing.
- Support professional development of BFI lead by allocating protected time and budget for them to attend UNICEF UK BFI training, National

Infant Feeding Network (NIFN) meetings, regional infant feeding strategy groups and infant feeding or maternity care conferences.

- Conduct regular audits of staff knowledge and practical skills, including observation and simulation assessments. Use audit findings to inform targeted education and support.
- Conduct regular audits of the consistency of infant feeding information provided across antenatal, intrapartum, and postnatal care.
- Conduct audits of women's satisfaction with the education and support received from maternity staff. Include questions in Friends and Family Test to identify variation and gaps to care to inform staff training, communication and care planning.
- To meet NICE and DH recommendations, include service user feedback on infant feeding support as a key quality metric.
- Celebrate BFI milestones with visible displays for staff and service users.
- Develop a CPD calendar aligned with NMC requirements focused on infant feeding and woman-centred care.
- BFI lead and management team to meet monthly to review practice issues and promote innovations.
- Use findings of audits to drive service improvement and celebrate good practice.

10.2 Areas for future research

There are two areas where future research would be beneficial. An exploration of BFI knowledge of medical staff who work with women and babies and how they incorporate the standards into their daily practices and an exploration of how student midwives who attend a BFI accredited university provide infant feeding support within a maternity unit without accreditation.

10.3 Strengths and limitations of this study

The COVID-19 pandemic became the major limitation. The study site was a small rural maternity unit with a stable workforce. A multisite case study was planned to enable a comparison to BFI accredited units however this could not

take place due to the pandemic restrictions. These restrictions also inhibited data collection methods leaving semi- structured interviews as the only data collection method with participants. The pandemic placed self-isolating restrictions on the population, this included maternity staff who have worked within the maternity service for more than 15 years, which restricted access to this group of staff as potential participants.

Consideration should be given to my position as an insider researcher and how that impacted the development of the interview guides and the depth of probing to answers given by the participants. There were times where I felt that I knew what the participant was alluding to, an outsider researcher would not have this additional knowledge therefore would have probed further resulting in a richer data set. During data analysis I identified that participants could have been questioned further regarding their perceptions and feelings of the maternity unit losing BFI accreditation.

My role as a BFI lead midwife may have influenced the response participants supplied throughout the interviews for fear of 'getting them wrong', more clarification could have been gleaned from participants in situations where we both assumed I was aware of what they were discussing. Those who were especially keen to participate may have had bias towards the BFI or have professional or personal agendas.

The strengths of the study are that I had access to the participants during the pandemic due to working clinically, this enabled interviews where otherwise that would have been a challenge. I feel that I was a trusted member of staff and therefore participants were comfortable to be open and honest with me throughout the interviews.

One of the main strengths of this work is the applicability of my findings and recommendations to NHS trusts who wish to successfully implement or maintain the UNICEF UK BFI within their maternity service. What I have contributed to the field of knowledge is highlighting the requirement for managerial belief and support of the BFI, alongside supporting a BFI lead role

within their maternity service who is supported by educated staff. Transparency of the accreditation process and job expectations of all staff is essential.

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Appendices

Appendix 1 Consent form

IRAS ID: 274438

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **Barriers, challenges and facilitators of implementing the Baby Friendly Initiative (BFI) in a maternity organisation: A qualitative study of maternity staff experiences.**

Name of Researcher: **Hazel Tennant**

Please initial box

1. I confirm that I have read the participant information sheet (dated 25/09/2019 version 1.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I have been given access to the BU Research Participant Privacy Notice which sets out how we collect and use personal information (https://www1.bournemouth.ac.uk/about/governance/access-information/data-protection-privacy). ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
4. I understand that the information held and maintained by Bournemouth (BU) and Dorset County Hospital (DCH) may be used to contact me. ☐
5. I agree to take part in the above study. ☐
6. I understand that taking part in the research will include the following activities as part of the research: being audio recorded during the interviews and focus groups, my words will be quoted in publications, reports, web pages and other research outputs without using my real name.

When completed: 1 for participant; 1 for researcher site file.

I confirm my agreement to take part in the project on the basis set out above.

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 2 Interview guide

Version 1.0 26.09.2019

Sample interview questions.

1. Tell me what BFI training you have received (if any) and where this took place.
2. I am not assessing you, tell me what knowledge of the BFI standards you have?
3. What learning and updating opportunities do you have/are available at DCH?
4. Tell me what experience you have of implementing BFI standards
5. Tell me what your thoughts are regarding BFI
6. What do you see as the reasons for having BFI accreditation in this maternity unit?
7. What do you think prevents you implementing BFI standards?
8. What do you think facilitates you implementing BFI standards?
9. Is there anything else you would like to add?

Sample interview questions for management and infant feeding leads.

1. Tell me what BFI training you have received and where this took place.
2. Have you worked in other units that are BFI accredited, tell me about this, do you recognise any differences or similarities?
3. What do you see as the reasons for having BFI accreditation in a maternity unit?
4. If applicable, what do you think prevents you implementing BFI standards?
5. What do you think facilitates you implementing BFI standards?
6. Is there anything else you would like to add?

Sample interview questions for neonatal unit staff.

1. What knowledge of the BFI standards do you have?
2. Tell me what BFI training you have received (if any) and where this took place.
3. Tell me what infant feeding support do you provide babies?
4. What infant feeding support do you provide parents?
5. What do you think prevents you implementing BFI standards?
6. What do you think facilitates you implementing BFI standards?
7. Is there anything else you would like to add?

Appendix 3 Participant information sheet

Participant Information Sheet

Study title:

Barriers, challenges and facilitators of implementing the Baby Friendly Initiative (BFI) in a maternity organisation: A qualitative study of maternity staff experiences.

Invitation to take part

- You are being invited to take part in a research project. Please take time to read the following information carefully and discuss it with others if you wish.

Who is funding the research?

- I'm Hazel Tennant, a postgraduate researcher and practising midwife at Dorset County Hospital (DCH). I am responsible for carrying out this study.
- This research project is jointly funded by Dorset County Hospital (DCH) and Bournemouth University (BU).

What is the purpose of the research?

- Dorset County Hospital has Unicef Baby Friendly Initiative (BFI) accreditation. In 2018 Unicef assessors found that requirements for successful re-accreditation were not met therefore leaving DCH vulnerable to losing full BFI accreditation. The purpose of this research is to explore maternity unit staff experiences of BFI, with the aim and objectives being to identify barriers, challenges and facilitators of BFI in practice.

Why have I been chosen?

- We would like to interview staff with training in and with experience of working with the BFI. Neonatal staff, staff in specialised infant feeding roles and maternity unit

management are also invited to participate in this research. Focus groups will follow interviews.

- It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a participant consent form which will include your name and job role.
- You can withdraw from the study at any time and without giving a reason. If you decide to withdraw we will aim where possible to remove any data collected about you from the study.
- Once the interviews and focus groups have finished and up to the point where the data is analysed and incorporated into the research findings or outputs, you may still withdraw from the study. However at this point your data will be anonymous, therefore your identity cannot be determined and it may not be possible to identify your data within the anonymous dataset.

What would taking part involve?

- You will be asked to take part in a single, individual interview with the researcher to talk about your knowledge and experience of BFI in practice.
- This interview could take place either face to face in a private room within the Research & Innovation department, at your home or via video call using platforms such as WhatsApp, Facebook messenger or Skype.
- It is anticipated that the interviews will last between 30 minutes to 1 hour and will be audio-recorded.
- Focus groups (FG) involving DCH staff only will follow interviews at a later date. These participants will be invited to attend a private room at DCH for a group discussion regarding BFI in practice. There is no expectation that participants who have been interviewed must attend a focus group.
- Currently there are restrictions due to Covid-19 lockdown. This may determine that interviews and focus groups will be held online via video/webcam.

What are the advantages and possible disadvantages or risks of taking part?

- The topic of infant feeding may be a sensitive matter to you therefore referral to Care First, occupational health or your manager will be completed if required.
- The benefits of this research are that it has the potential to identify valuable insights into how BFI could be implemented more easily and the current challenges that need

to be overcome. This can inform managers, infant feeding leads and all those staff supporting mothers and babies within DCH.

What information will I be asked and why is the collection of this information relevant?

- You will be asked to tell the researcher what you know about BFI and what your experience is of working with the BFI standards within your professional practice.
- Your experiences will form the main findings of the study which will fulfil the projects objectives by contributing to knowledge and potentially enhancing care for our service users.

Will I be recorded and how will the recorded media be used?

- The audio recordings of your activities made during the interviews and focus groups will be used for analysis to form the researcher's thesis.
- The anonymous transcription of the recording may be used in conference presentations and lectures.
- No other use will be made of them without your written permission and no one outside the research project will be allowed access to the original recordings.

How will my information be kept?

- All the information collected about you during the course of the research will be kept strictly in accordance with current data protection legislation. Research is a task that is performed in the public interest, as part of a core function as a university. Bournemouth University (BU) is a Data Controller of your information which means that they are responsible for looking after your information and using it appropriately. BU's Research Participant Privacy Notice sets out more information about how they fulfil their responsibilities as a data controller and about your rights as an individual under the data protection legislation. https://www.bournemouth.ac.uk/about/governance/access-information/data-protection-privacy/research-participant-privacy-notice
- We will need to use information from you for this research project. This information will include your name and initials. This information will be used to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or initials. Your data will have a letter code instead.

- We will keep all information about you safe and secure.
- Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/transparency-wording-for-all-sponsors/

Publication

- You will not be able to be identified in any external reports or publications about the research without your specific consent to waiver anonymity.
- Research results will be published as part of the researcher's PhD thesis; they will also be written up in the required style for medical, midwifery and science journals and submitted for publication.

Security and access controls

- BU will hold the information collected about you in hard copy in a secure location and on a BU password protected secure network where it is held electronically.
- Your personal information will be accessed and used only by appropriate, authorised individuals and when this is necessary for the purposes of the research or another purpose identified in the Privacy Notice.
- This may include giving access to BU staff or others responsible for monitoring and/or audit of the study who need to ensure that the research is complying with applicable regulations.
- You will be identified by a unique code which is linked to your signed consent form. All project paperwork will be stored in a locked filing cabinet within the Research & Innovation department at DCH that only the researcher will have access to.
- A computerised list of participants with their code will be held on the researcher's university computer which is password protected, it will be saved in a separate location to other research data.

Sharing and further use of your personal information

- The information collected about you may be used in an anonymous form to support other research projects in the future and access to it in this form will not be restricted. It will not be possible for you to be identified from this data.
- Anonymised data will be added to BU's Data Repository (a central location where data is stored) which will be publicly available.

Retention of your data

- All personal data collected for the purposes of this study will be held for 5 years after final completion of the research and after the award of the degree.
- Although published research outputs are anonymised, BU need to retain underlying data collected for the study in a non-anonymised form for a certain period to enable the research to be audited and/or to enable the research findings to be verified. This will be stored within BU repository system. https://bordar.bournemouth.ac.uk

Contact for further information

If you have any questions or would like further information, please contact myself or any members of the research team:

Researcher:

- Hazel Tennant (Parker)
  - Call/text/WhatsApp: 07563150398
  - Email: Hazelparker.research@dchft.nhs.uk

Research Supervisors:

- Professor Edwin Van Teijlingen
  - Tel: 01202 961564
  - Email: evteijlingen@bournemouth.ac.uk
- Dr Alison Taylor
  - Tel: 01202 961548
  - Email: ataylor@bournemouth.ac.uk
- Rosie Read
  - Tel: 01202 961771
  - Email: rread@bournemouth.ac.uk

Bournemouth University, Faculty of Health and Social Sciences, Fern Barrow, Poole, BH12 5BB.

In case of complaints

- Any concerns about the study should be directed to Professor Vanora Hundley, Deputy Dean for Research & Professional Practice, Faculty of Health & Social

Sciences, Bournemouth University by email to researchgovernance@bournemouth.ac.uk.

Finally

- If you decide to take part, you will be given a copy of the information sheet and a signed participant consent form to keep.

Thank you for considering taking part in this research project.

Appendix 4 Recruitment poster

IRAS number: 274438 Version 1.0

Bournemouth University

25.09.2019

Calling the midwives, support workers and student midwives! Do you have training and experience in the Baby Friendly Initiative (BFI)? If yes then I am inviting you to participate in my research project as below:

Barriers, challenges and facilitators of implementing the Baby Friendly Initiative (BFI) in a maternity organisation: A qualitative study of maternity staff experiences.

Before you decide to participate it is important for you to understand why the research is being done and what it will involve.

Why am I doing this research?

DCH has Unicef Baby Friendly Initiative (BFI) accreditation. In 2018 Unicef assessors found that requirements for successful re-accreditation were not met therefore leaving us vulnerable to losing full accreditation. The purpose of this research is to explore your experiences of the BFI, with the aim of identifying barriers, challenges and facilitators of BFI implementation in a maternity unit.

Do ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If you do decide to take part, please contact me on the details below so that I can give you a participant information sheet with further details of the study.

Hazel Parker
RM and PhD researcher.
Call/text/Whatsapp: 07563150398
Email: Hazelparker.research@dchft.nhs.uk / S5125108@bournemouth.ac.uk